STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148 NAME OF PROVIDER OR SUPPLIER		A. BUILDING B. WING	CONSTRUCTION 00 T ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED 02/07/2013		
NORTH PARK N			650 FAIRWAY DR EVANSVILLE, IN 47710			
`	ACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE	
This visul nesting Survey Februar Facility Provide AIM numbers of Survey Amy Warb Facility Provide AIM numbers of Survey Amy Warb Facility Facility Survey Amy Warb Facility Facility Survey Amy Warb Facility Facilit	sure Survey isit was in c igation of Co y dates: Jan ary 1, 5, 6, 7 y number: (ler number: 1002 y team: Vininger, RN Hancock, F us bed type: Us payor typ are: aid:	onjunction with the omplaint #IN00123081. nuary 28, 29, 30, 31, and 7, 2013 000069 155148 288980 N TC RN 12 84 96	F0000	The creation and submission of this plan of correction do not constitute an admission this provider of any conclus set forth in the statement of deficiencies, or of any violat of regulation. Due to the relation scope and severity of the survey, the facility respectfur requests a desk review in life of a post-survey revisit on after March 1, 2013. Thank you, Judith Carter, Executive Director North Park Nursing CenterEvansville Indiana 47710812-425-5243	es by sion tion tive his ully	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Page 1 of 80 Event ID: 3TWK11 Facility ID: 000069 If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/12/2013 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155148	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM 02/0	TE SURVEY MPLETED 07/2013		
	PROVIDER OR SUPPLIER PARK NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	in accordance with 410 IAC 16.2.						
	Quality review completed on February 14, 2013, by Jodi Meyer, RN						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 2 of 80

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/07/2013		
	PROVIDER OR SUPPLIEF		STREET	STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F0242 SS=D	MAKE CHOICES The resident has activities, schedul consistent with hill assessments, an with members of and outside the flabout aspects of that are significant. Based on interreview, the fact of 3 residents of threshold, were often they received (Resident #62, Findings included). During interion 1/28/13 at 2 he was suppose week but had one bed bath showers and with the two showers. Resident #62's reviewed on 2/2 record indicated admitted to the with diagnoses.	the right to choose tles, and health care is or her interests, d plans of care; interact the community both inside acility; and make choices his or her life in the facility nt to the resident. view and record ility failed to ensure 2 reviewed for choices, in 5 who met the e able to choose how eived showers. Resident #118) de: view of Resident #62 2:38 p.m., he indicated sed to get 2 showers a conly had 2 showers and since he was admitted. e had not refused any yould have liked to have rs a week at least. d clinical record was 1/13 at 12:30 p.m. The d the resident was a facility on 12/22/12 a including, but not etes mellitus and	F0242	F242 Self Determination- Righmake choices 1.Resident #62 discharged of 2/2/2013 and resident #118 discharged on 2/4/2013. 1.All residents have the potential to be affected by the alleged deficient practice. All residents were interviewed us the Activity Questionnaire regarding shower choices. Careplans were updated to reresident preference regarding showers as needed. Nursing swere in serviced 2/12/13 per son the shower schedule, resident related to showers. Shower schedules have been audited ensure that each resident is scheduled for the number and time of their shower (minimum two showers per week) and revisions were made to including resident preferences as indicated. 3. Nursing staff were in serviced 2/12/13 per SDC on the show schedule, resident preference and documentation related to showers. Master shower	ing flect staff SDC lent on to in of e sted. ced er	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet Page 3 of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155148	B. WIN			02/07/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	R.		650 FAI	RWAY DR		
NORTH F	PARK NURSING C	ENTER			VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
	Resident #62's Data Set [MDS 12/29/12, indic out of 15 on the Mental Status impairment]. T plan, dated 1/3 limited to, the f "Encourage resin care such as preference, etc times per week between." The Activities of were reviewed review. The resident received days except the 1/1/13 BB [bed 1/4/13 BB 1/11/13 showe 1/21/13 B [bed 1/24/13 showe 1/29/13 showe 1/29/13 at 9:16 indicated durin two showers a preferred to ge 5:00 a.m. and sall his life. He	admission Minimum a assessment, dated ated he scored a 14 be Brief Interview for [minimal cognitive The resident had a care a/13, including, but not collowing interventions: sident to make choices a clothing, shower time be" "Provide shower 2 ax, partial bath in of Daily Living records as part of the record becords indicated the ed partial baths on all be following: bath] r bath] r bath] r bath] r bath ginterview he received week. He indicated he t up every day around shower, he'd done that indicated, "they are			schedule will be updated as needed per DNS/designee updated completion of the admission questionnaire and as indicated per resident interview results. Charge nurses will conduct rounds daily to ensure resident are offered and receiving show per resident preferences. Nurse staff will be required to sign the shower sheet in acknowledgement of completion of the shower and/or refusal of shower. 4. DNS/ designee will complete resident interview monitoring tool 5x week for 2 weeks, 3x week for 2 weeks, 3x week for 2 weeks, 4 week for 2 weeks, then weekly 6 weeks and monthly for 3 months to ensure residents has choices in care. Results of resident interview monitoring to will be reviewed in the monthly CQI meeting for a minimum of 6 months, if a threshold of 95% not met an action plan will be developed. 5. Completion Da March 9 th, 2013	ts vers sing e on f x ve ool v 6 is	
		indicated, "they are 2 showers a week."					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155148	B. WING		02/07/2013	
NAME OF	PROVIDER OR SUPPLIEI	· }	STREET .	ADDRESS, CITY, STATE, ZIP CODE	•	
				IRWAY DR		
NORTH	PARK NURSING C	ENTER	EVANS	SVILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	reviewed on 2/ resident's adm Set [MDS] ass 12/14/12, indic out of 15 on th	's clinical record was '1/13 at 12:25 p.m. The ission Minimum Data essment, dated cated he scored a 15 e Brief Interview for indicating no cognitive				
	The resident's was not limited activities of da deficit, dated 1 included, but v following: "Enmake choices clothing, show etc." "Provide	care plan included, but I to, a care plan for ily living, self care 2/21/12. Interventions were not limited to, the courage resident to in care such as er time preference, shower two times per ath in between.				
	were reviewed indicated the repartial bath on following wher 1/1/13, 1/4/13, 1/13/13, 1/16/2 3. On 2/6/13 a Director of Nur Resident #62 I not getting a sintravenous lin	of Daily Living records for January, 2013 and esident received a all days except the he received a shower: 1/9/13, 1/11/13, 13, 1/24/13. at 2:00 p.m., the reses [DoN], indicated had complained about hower. He had an e in one arm and a ere treating on his other				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/12/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155148	A. BUILDING B. WING		COMPLETED 02/07/2013			
	PARK NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PRFFIX (EAC	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE			
	foot. The direct care staff did not think they could give him a shower; she indicated they were instructed on how to cover the areas for showers and she thought the issue had been resolved. She thought it was 3 or 4 weeks ago it had been addressed. After reviewing the shower documentation, the Nurse Consultant and DoN indicated they had found some discrepancies in the shower list and the nurse aide assignment sheets for when residents were to get showers. This review had occurred 2/5/13. 3.1-3(u)(1)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 6 of 80

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED		
		155148	B. WIN			02/07/2013		
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER				IRWAY DR			
NORTH I	PARK NURSING CE	ENTER			VILLE, IN 47710			
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	MONITORING BY AN OF CONDUCTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	-	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	I E	DATE	
F0253 SS=E	SERVICES The facility must personal maintenance servers a sanitary, orderly Based on obse	orovide housekeeping and vices necessary to maintain v, and comfortable interior.	F02	53	F253 Housekeeping &		03/09/2013	
	resident rooms were clean in the rooms and/or be (Room #112, Re #115, Room #1	lity failed to ensure and/or bathrooms hat, 9 of 34 resident eathrooms were soiled. Room #114, Room 149, Room #150, boom #152, Room			Maintenance Services 1. Resident rooms/ bathrooms #112,114,115,149,150,151,15 54,155 have been cleaned. Signail in room 154 was secured. All residents have the potentia be affected by the alleged deficient practice. All resident rooms/bathrooms were thoroughly cleaned.	de 2.		
	1/29/13 at 9:52 bathroom floor	of room #149 on a.m., indicated the had a liquid in the floor			Housekeeping staff were in serviced on 2/25/13 per housekeeping supervisor relat to guidelines for cleaning resid rooms and bathrooms. Facility audit completed to ensure that side rails were secure with	ent		
	 Observation 1/29/13 at 9:33 bathroom floor build-up of dirt around the bas Observation 1/29/13 at 9:31 bathroom floor base of the corhad a strong un 	e of the commode, of room #150 on a.m., indicated the was dirty with a in the corners and eboard of the floor. of room #151 on a.m., indicated the was wet around the mmode, the bathroom rine odor, and a small vas on the commode			corrective action as needed. Housekeeping staff were in serviced on 2/25/13 per housekeeping supervisor relat to guidelines for cleaning resid rooms and bathrooms. Housekeeping and maintenance services will be provided to maintain a sanitary, orderly an comfortable interior. Rounds we be conducted daily per Housekeeping supervisor/ designee to ensure rooms are cleaned according to the facility cleaning guidelines. If rooms a not cleaned appropriately room will be recleaned to ensure the room is cleaned according to the services.	ed dent d rill y re ns		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet Page 7 of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155148	B. WIN			02/07/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	2					
NORTH F	PARK NURSING C	FNTFR	650 FAIRWAY DR EVANSVILLE, IN 47710				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
					standards. Rounds will be		
	Observation	n of room #152 on			conducted daily per Maintenar		
	1/29/13 at 9:28	a.m., indicated the			Director/ designee to ensure s	iae	
	bathroom floor	was sticky and dirty.			rails are secure in all rooms. 4.Housekeeping		
					supervisor/ designee will		
	5 Observation	n of room #154 on			complete housekeeping		
					monitoring tool 5x week for 2		
		a.m., indicated the			weeks, 3x week for 2 weeks, 2	2x	
		was sticky and dirty			week for 2 weeks, then weekly		
		I was attached properly			6 weeks and monthly for 3		
	but was loose	on the resident's right			months to ensure that resident	-	
	side of the bed.				rooms and bathrooms are clea		
					Failure to comply with guidelin		
	6 Observation	n of room #155 on			will result in disciplinary action	up	
		a.m., indicated the			to and including termination.		
		•			Maintenance Director/ designe will complete side rail monitori		
		was sticky and dirty			tool 5x week for 2 weeks, 3x	iig	
		owels and an empty			week for 2 weeks, 2x week for	2	
	glove box in th	e bathroom.			weeks, then weekly x 6 weeks		
					and monthly for 3 months.		
					Results of housekeeping		
					monitoring tool and side rail		
					monitoring tool will be monitor		
					in the monthly CQI meeting for	ra	
					minimum of 6 months, if a		
					threshold of 95% is not met ar		
					action plan will be developed.	5.	
					Completion Date: March 9 th, 2013		
					2013		
	7 Dag 4445	Succession of the second					
		was observed on					
		2 p.m. There was dirt					
	and debris beh	ind the bedroom door.					
	8. Room #112	was observed on					
	1/29/13 at 1:42	p.m. The bathroom					
		d with a gray build-up in					
	uie comers am	d edges. There was a					

	OF CORRECTION IDENTIFICATION NUMBER: 155148	A. BUILDING B. WING	00	COMPI 02/07	LETED
	ROVIDER OR SUPPLIER PARK NURSING CENTER	STREET A	ADDRESS, CITY, STATE, ZIP COI IRWAY DR SVILLE, IN 47710	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	3 inch rust stain on the back wall of the bathroom.				
	9. Room #114 was observed on 1/29/13 at 1:34 p.m. There was a large brown smear on the front of the toilet and debris in the corner behind the bedroom door. The "Cleaning Guidelines," obtained on 2/7/13 at 8:30 a.m from the DoN [Director of Nursing], indicated the resident's rooms and restrooms are to be cleaned and disinfected and the paper towels are to be replenished daily. The guidelines indicated the commonly touched areas were to be cleaned and disinfected and the exterior of the toilet was to be wiped daily. 3.1-19(f)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 9 of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155148	ı			02/07/	2013
		100 1 10	B. WIN			02/01/	2010
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					RWAY DR		
NORTH PARK NURSING CENTER			EVANS	VILLE, IN 47710			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0272	483.20(b)(1)						
SS=E		VE ASSESSMENTS					
	•	conduct initially and					
		nprehensive, accurate,					
	·	roducible assessment of					
	each resident's functional capacity.						
	Δ facility must ma	ake a comprehensive					
		resident's needs, using the				ļ	
		nent instrument (RAI)					
		State. The assessment					
	must include at le						
		demographic information;					
	Customary routin	e;					
	Cognitive patterns	s;					
	Communication;						
	Vision;						
	Mood and behavi						
	Psychosocial wel						
	Physical functioni	ing and structural					
	problems;						
	Continence;	11 10 20					
		s and health conditions;					
	Dental and nutritions;	onai status;					
	Activity pursuit;						
	Medications;						
	•	ts and procedures;					
	Discharge potenti						
		f summary information					
		ditional assessment					
		care areas triggered by					
	the completion of	the Minimum Data Set					
	(MDS); and						
	Documentation of	f participation in				ļ	
	assessment.						
	Based on obse	rvation, interview and	F02	72	F272 Comprehensive	İ	03/09/2013
	record review.	the facility failed to			Assessments 1. Dental conse	nts	
	•	hensive assessments			have been obtained for resider	nt	
	-	ected the residents'			#29 and resident #111. Both	ļ	
	•				residents have dental	ļ	
	status, for / of	44 Stage 2 sampled			examination scheduled at this		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 10 of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPL	ETED
		155148				02/07/	2013
			B. WIN		ADDRESS STEVENS TO THE STATE OF		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
NODTIL		ENTER			IRWAY DR		
NORTH PARK NURSING CENTER			EVANS	VILLE, IN 47710			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	residents, in th	at psychoactive			time. MDS assessments modi		
	medications, d	ental status, and skin			and resubmitted as indicated		
	issues were no	ot reflected on the			residents'#9, #11 #65, #124, #	‡ 25,	
	assessments.	(Resident #29,			#32 and #50.		
		, Resident #65,			2.All residents have the potential to be affected by the		
		, Resident #25,			alleged deficient practice.Faci		
					audit completed to ensure tha		
	Resident #32,	Resident #50)			dental consents have been		
					obtained and dental services		
	Findings includ	le:			scheduled as indicated. IDT a	and	
					nursing staff in serviced on		
	1. Resident #2	29's record was			2/26/13 per SDC related to de		
	reviewed on 1/	30/13 at 2:10 p.m.			services. Audit of assessment	S	
	Resident #29 d	diagnoses included, but			pertaining to psychotropic medications and skin issues w	oro.	
		to, bipolar disorder,			completed to ensure	/ere	
		e cancer, anxiety and			assessments reflect the		
		aortic aneurysm.			resident's status.		
		aortic arieurysin.					
	The second NAT	20. 4-4-4 4/0/40			3. IDT and nursing staff in		
		DS, dated 4/6/12,			serviced on 2/26/13 per SDC		
		dent #29 had no dental			related to dental services. IDT	will	
	•	e assessment did not			review each care plan and		
	indicate the res	sident had dentures.			assessment during the reside		
	The quarterly N	MDS, dated 11/14/12,			reference period, to compare MDS assessment with the	lile	
	did not indicate	e any dental issues.			resident care plan and current		
		•			resident needs. DNS/designed		
	Resident #29 v	vas interviewed on			will reviewed the assessments		
		a.m. On interview the			ensure accuracy prior to		
		ted she had loose			transmission.		
		ident #29 indicated her			4.DNS/designee will complete		
		at least 20 years old			assessment monitoring tool 5		
		ot been to the dentist in			week for 2 weekse monitoring		
	-	e. The resident			tool 5x week for 2 weeks, 3x week for 2 weeks, 2x week for	. 2	
	indicated she h	nad been able to chew			week for 2 weeks, 2x week for weeks, then weekly x 6 weeks		
	without difficult	y but probably needs			and monthly for 3 months to	•	
		ents to her dentures.			ensure dental consents and		
					services are provided as		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIHI DING	A. BUILDING 00			COMPLETED	
		155148	B. WING			02/07/2013		
			_	EET A	DDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIE	K			RWAY DR			
	PARK NURSING C		EV		VILLE, IN 47710			
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL	1	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)	TAC	j	DEFICIENCY)	4	DATE	
		111's record was			indicated. Results of assessment monitoring tool and dental services.			
		/30/13 at 1:00 p.m.			monitoring tool will be monitored			
		had a diagnoses of,			in QA for a minimum of 6 mon			
		to, dementia, anxiety,			if a threshold of 95% is not me	t		
	hypertension,	and hyperlipidemia.			an action plan will be develope 5. Completion Date: March 9			
	Resident #111	's admission MDS			2013			
		esident had no dental						
		uarterly MDS, dated						
	•	indicated the resident						
	· ·	ny dental issues.						
	did flot flave al	ny dentan issues.						
	Resident #111	's family and POA						
		ney] was interviewed						
		12:41 p.m. Resident						
		•						
	1	POA indicated the						
		pose teeth and had lost						
		eth since coming to the						
		elt the resident's gums						
		Resident #111's						
	1	dicated the resident had						
		tist in the past but had						
		al visit since her						
	admission to the	ne facility in April, 2012.						
		SW #1 on 2/1/13 at						
	10:44 a.m., inc	dicated that residents						
	#29 and							
	#111, had not	had a dental visit since						
	being admitted	I to the facility. SW #1						
	_	did not know the either						
	resident had a	ny dental issues. SW						
		ne could not locate the						
		ntal services that is						
		ne resident is admitted						

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/07/2013
	PROVIDER OR SUPPLIE		650 FA	ADDRESS, CITY, STATE, ZIP CODE IRWAY DR SVILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	would need to the resident's residents have for services and the resident's resident to have appointment. The resident could in the facility of their own dentification and their own dentification and the facility of the facility of their own dentification and the facility of the facility o	SW #1 indicated the be visited by a dentist of the resident could visit ist. Interview with SW to 9:56 a.m., indicated and through" both of the lical records and was the where either dental visit. 65's record was (30/13 at 3:45 p.m.) had diagnoses of, but noderate dementia, thus type 2, anxiety, and resophageal reflux had an order, dated eroquel [an medication] 25 mg 1 h daily at bedtime. The assessment, dated cated the resident had			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet Page 13 of 80

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155148	B. WIN	G		02/07/2	2013
NAME OF P	PROVIDER OR SUPPLIEF	.		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					RWAY DR		
NORTH	PARK NURSING C	ENTER		EVANS	VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	REGULATORT OR	LESC IDENTIFTING INFORMATION)		TAG			DATE
	4 Posidont #1	124's record was					
	reviewed on 1/31/13 at 9:05 a.m. Resident #124 had a diagnoses of,						
		to, psychosis and					
	dementia with						
	disturbances.	Bellaviolai					
	2.0.0.000.						
	Resident #124	had been hospitalized					
	from 11/6/12 through 12/14/12 for						
		returned to the facility					
		th the following					
	medications or	•					
	Risperdal Cons	st [an antipsychotic					
	medication] 12	.5 mg [milligrams] / 2					
	ml [milliliters] II	M [intramuscularly]					
	every 2 weeks	, which had been					
	started on 12/4	l/12.					
	Remeron [an a	ntidepressant					
	medication] 15	mg p.o. [orally] at					
	bedtime, which	n had been started on					
	12/1/12.						
		notic medication] 5 mg					
	'	y prn [as needed],					
		n started on 12/1/12.					
		ad been on Risperdal					
	'	,5 ml - give 0.5 ml p.o.					
		h meals started on					
	12/8/12 and dis	scontinued on					
	12/22/12.						
	The educies:	MDC datad 40/04/40					
		MDS, dated 12/21/12,					
		the resident had					
	received any o						
	medications du	uring the last 7 days or					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet Page 14 of 80

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	TED
		155148	B. WIN			02/07/2	2013
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹		650 FAI	RWAY DR		
NORTH I	PARK NURSING C	ENTER			VILLE, IN 47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
	since admissio	on/entry if less than 7					
		day scheduled MDS					
	,	ated 1/9/13, indicated					
		ceived an antipsychotic					
	_	7 days or since					
	admission/entr	ry if less than 7 days.					
	E Decident "	Office and one of					
		25's record was					
		/1/13 at 2:45 p.m.					
		nad a diagnoses of, but					
		ntertrochanteric					
	fracture of the	right hip, right below					
	the knee ampu	ıtee, Alzheimer's					
	disease, deme	ntia with behavior					
	disturbances,e	pilepsy, and CVA					
	[cerebral vascu						
	l -	was admitted with a					
		n on his right hip area.					
	our grour moiore	on the right inplaced.					
	The admission	MDS assessment,					
		indicated a clinical					
	-	the resident's skin					
		been performed but					
		e the resident had a					
		ny prominence, or a					
	non-removable	e dressing/device.					
	The discharge	MDC coccers and					
	_	MDS assessment,					
		2, did not indicate the					
		scar over a bony					
	1 .	a non-removable					
	dressing/devic	e.					
	Interview with	the MDS Coordinator					
	on 2/1/13 at 11	1:20 a.m., indicated he					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 15 of 80

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ì		NSTRUCTION 00	(X3) DATE S COMPLI	
		155148	A. BUII B. WIN	LDING G		02/07/	2013
	PROVIDER OR SUPPLIEF			650 FAI	NDDRESS, CITY, STATE, ZIP CODE RWAY DR VILLE, IN 47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	obtains the chargoes through MDS Coordinater reason why MI skin condition aresident #25. did not give a rwas incorect for 25, and 124. The MDS Coordinater MDS 2012, and after employment, the Coordinator left. Coordinator left. Resident was or dining/activity are activity. She was observed sound asleep. Resident #32's reviewed on 1/1. The resident was facility on 7/15, including, but resident participations.	art upon admission and it" for orders. The stor did not give a DS was incorrect for the assessment for The MSD Coordinator reason why the MDS or residents #29, 65, and and it in the activity area in the activity area in the activity area in the activity. At 1/31/13, the resident in her room in her chair in the activity. At 1/31/13, at 10:10 a.m. reas admitted to the interest and in the activity. At 1/31/13 at 10:10 a.m. reas admitted to the interest and in		TAG		TE	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 16 of 80

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155148	B. WING		02/07/2013
NAME OF P	PROVIDER OR SUPPLIEF	3	STREE	T ADDRESS, CITY, STATE, ZIP CODE	
				AIRWAY DR	
NORTH F	PARK NURSING C	ENTER	EVAN	ISVILLE, IN 47710	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	cerebrovascula	ar disease, and			
	arthropathy.				
	The physician's orders, signed				
	1/29/13, includ	ed, but were not limited			
	to, the following	g:			
		ntianxiety] 0.25 mg 1			
		at bedtime *hold for			
	sedation* since				
	Lexapro [antide	epressant] 20 mg po			
	daily				
	Risperidone [a	ntipsychotic] 0.25 mg			
	one twice a da	y since 8/25/11"			
	Resident #32's	annual Minimum Data			
	Set [MDS] ass	essment, dated			
	6/12/12, indica	ted the resident was			
	receiving an ar	ntianxiety medication			
		ressant medication but			
	failed to indica	te the resident was			
	receiving an ar	ntipsychotic medication.			
	Resident #32's	quarterly MDS, dated			
		ated the resident was			
	·	ntianxiety medication			
	_	ressant, but failed to			
		sident was receiving an			
	antipsychotic n	•			
	The Director of	f Nurses and Nurse			
		icated during interview			
	on 2/6/13 at 2:	~			
		nould be indicated on			
	the MDS.	iodia do indicatoa on			
	uic wibo.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet Page 17 of 80

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING	00	COMPL	
		155148	B. WING			02/07/	2013
NAME OF P	PROVIDER OR SUPPLIEF	3	5	STREET A	DDRESS, CITY, STATE, ZIP CODE		
					RWAY DR		
NORTH F	PARK NURSING C	ENTER		EVANS\	VILLE, IN 47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		50's clinical record was					
	reviewed on 1/30/13 at 11:05 a.m. The resident was admitted to the facility on 12/2/12, with diagnoses including, but not limited to,						
		, dementia and					
		She was transferred					
		ic psychiatric unit on					
	12/5/12, and re	eturned to the facility on					
	12/21/12.						
	Record include	ed, but were not limited					
		orders, dated 12/24/12					
	at 10:30 a.m.,	for the following					
	medications:						
	Haldol [antipsy	chotic medication] 5					
	milligrams [mg] at 1600 [4:00 p.m.]					
	that date and e	every 6 hours as					
	needed for ext	reme anxiety/agitation.					
	Geodon [antips	sychotic medication] 40					
	mg by mouth d	laily to start 12/25/12.					
	Upon admission	on 12/21/12, the					
	resident also h	ad orders for					
	Lorazepam [ar	ntianxiety medication]					
	0.5 mg by mou	ith every 4 hours as					
	needed. Revie	ew of the Medication					
	Administration	Record indicated the					
	resident receiv	ed lorazepam on					
		5/12, and 12/26/12.					
	Resident #50's	admission Minimum					
	Data Set [MDS	3] assessment, dated					
		ded, but was not					
	limited to, the f						
	<u> </u>						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet Page 18 of 80

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/12/2013 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER NORTH PARK NURSING CENTER IXAJI D SIMMARY STATIMENT OF DEPICIENCIES REGULATORY OR 1.SC IDENTIFYING INFORMATION TAG Antipsychotic medication received 7 days Antianxiety medication, none received 3.1-31(a)	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148		A. BUILDING B. WING DO COMPLETED 02/07/2013				
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Antipsychotic medication received 7 days Antianxiety medication, none received				650 FA	IRWAY DR		
days Antianxiety medication, none received	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
	IAG	Antipsychotic m days Antianxiety med	nedication received 7	IAG	DEPICIENCY)	DATE	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet Page 19 of 80

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CON	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	00	COMPL	ETED
		155148	B. WING			02/07/	2013
				TREET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				RWAY DR		
NORTH F	PARK NURSING CE	ENTER			/ILLE, IN 47710		
(X4) ID	STIMMADV S	FATEMENT OF DEFICIENCIES	ID		,		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TA		CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
F0279	483.20(d), 483.20		1	-			
SS=D	` ''	PREHENSIVE CARE					
00-D	PLANS	1. (E. 1.					
	A facility must use the results of the						
		evelop, review and revise					
	the resident's con	nprehensive plan of care.					
	The facility must develop a comprehensive						
	•	resident that includes					
	-	ctives and timetables to medical, nursing, and					
		•					
	mental and psychosocial needs that are identified in the comprehensive assessment.						
lacriance in the comprehensive access.							
	The care plan must describe the services						
		nished to attain or maintain					
		nest practicable physical,					
		hosocial well-being as					
		183.25; and any services					
		rise be required under not provided due to the					
		e of rights under §483.10,					
		t to refuse treatment under					
	§483.10(b)(4).						
		view and record	F0279	İ	F279 Develop Comprehensive	!	03/09/2013
	review, the faci	lity failed to develop a			Care Plans		
	care plan for 1						
	•	DL's [activities of daily			 ADL care plan developed 	b	
		age 2 sample of 44			for resident #65.		
	0.	were reviewed for care			O All regidents with as if		
					2. All residents with self car	e	
	plans. (Resider	ıı #05)			deficit have the potential to be affected by the alleged deficien	nt	
					practice. Facility audit complet		
	Findings includ	e:			for to ensure care plans have	-	
					been developed to address		
	Resident #65's	record was reviewed			residents' need for ADL		
	on 1/30/13 at 3:45 p.m. Resident # 65 had diagnoses of, but not limited				assistance. IDT in serviced		
					2/28/13 per RAI Specialist rela		
	•	mentia, diabetes			to development of comprehens	sive	
		anxiety, and GERD			care plans.		
	momus type 2,	and our	1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 20 of 80

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED	
		155148	B. WIN			02/07/2013	
NAME OF I	PROVIDER OR SUPPLIEI		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	NO VIDER OR SOLITEIE				IRWAY DR		
NORTH I	PARK NURSING C	ENTER		EVANS	VILLE, IN 47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ON
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
		geal reflux disease].			1.IDT in serviced 2/28/13 pe	r	
	During the resident's chart review on				RAI Specialist related to		
		5 p.m., the resident did			development of comprehensive	е	
		e plan to address her			care plans. All residents are		
	need for ADL a	assistance.			assessed at admission, quarte and with significant change fo		
	Deside : 4 #05!	UDanidant Ores /N			self care performance, those		
		Resident Care/Need			found to be deficient will have	a	
	_	IA assignment sheet]			care plan initiated for ADL		
		needed the assistance			assistance. Every resident has		
		her ADL's and had a			care plan review quarterly by to IDT team to ensure the	ne	
	transfer bar to the right side of her				assessment and care plan are		
		sfer bar was to be			accurate for each resident's		
		tured for increased			ADLs.		
	· ·	ess for the resident.			4 DNC/ designed will		
		cated the resident used			4. DNS/ designee will complete the care plan		
	1	r, had to be "set-up" for			monitoring tool 5x week for 2		
	_	eded encouragement			weeks, 3x week for 2 weeks, 2		
	every 2 nours	to go to the bathroom.			week for 2 weeks, then weekly	/ X	
	The guerterly	ADS Minimum Data			6 weeks and monthly for 3 months to ensure that care pla	ane	
		MDS [Minimum Data			address activities of daily livin		
	_	ent, dated 11/30/12, esident needed			Results of care plan monitori	ng	
		stance of 1 person with			tool will be monitored in QA fo	ra	
		xtensive assistance of			minimum of 6 months, if a threshold of 95% is not met ar	,	
	_	ansfers, extensive			action plan will be developed.	'	
		I person for dressing,					
		stance of 1 person for					
		sive assistance of 1			5. Completion Date: Mai	ch	
	_	sonal hygiene,and			9 th , 2013		
		ance in part of bathing					
		rson. The MDS					
		dicated the resident					
		and only able to					
	-	taff assistance for					
		eated to standing					
	I moving hom s	calcu to standing					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148		(X2) MULT A. BUILDIN B. WING		00	(X3) DATE S COMPLI 02/07 /2	ETED	
	PROVIDER OR SUPPLIER		S ² 6	50 FAIF	DDRESS, CITY, STATE, ZIP CODE RWAY DR /ILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PRE	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	moving on and surface to surfa MDS assessmo	ng, turning around, off the toilet, and ace transfers. The ent indicated the equently incontinent of					
	indicated the re assist for bed re eating, and toil	cord for January, 2013, esident is a 1-2 person nobility, transfers, et use. The record esident is incontinent					
	9:30 a.m., indic with her walker	PN #1 on 2/5/13 at cated the resident is up but is a 1 person bathing and dressing.					
	Nursing] on 2/6 indicated she of resident did no her ADL deficit residents in the	he DoN [Director of 6/13 at 3:30 a.m., lid not know the thave a care plan for s and most of the facility should a self-care deficit care					
	Maintenance, of obtained from the 8:30 a.m., indicates	•					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 22 of 80

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/12/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148		00 	COMPLETED 02/07/2013
	PROVIDER OR SUPPLIER PARK NURSING CENTER	650 FA	ADDRESS, CITY, STATE, ZIP CODE IRWAY DR SVILLE, IN 47710	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	comprehensive assessment. The policy indicated the care plan review will be based on the MDS schedule for those residents who had an admission, annual, significant change, quarterly, or Medicare MDS completed at a minimum of every 90 days. The policy indicated the care plan problems, goals, and interventions will be updated based on changes in resident assessment/condition, resident preferences, or family input. 3.1-35(a)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet Page 23 of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148		A. BUILD B. WING	ING	ONSTRUCTION 00	(X3) DATE S COMPLE 02/07/2	ETED	
	PROVIDER OR SUPPLIEF			650 FAI	ADDRESS, CITY, STATE, ZIP CODE RWAY DR VILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
F0282 SS=D	CARE PLAN The services profacility must be p	QUALIFIED PERSONS/PER vided or arranged by the rovided by qualified dance with each resident's re.	F0282	2	<u>F282</u> Services by qualified		03/09/2013
	review, the factoresident with a catheter receive the care plan, is reviewed for have the catheter not have the catheter according to the (Resident #B) Findings included The clinical receives reviewed as reviewed as reviewed p.m. The Physician dated 08/09/12 limited to, the "change f/c [catheter] q [ever [as needed] or the August 20 Administration documentation.	de: cord of Resident #B on 01/30/13 at 1:58 Admission Orders included, but was not following order indwelling urinary ery] month et [and] prn			person/ per care plan 1.Resident B discharged from facility on 1/17/13. 1.All residents requiring the of indwelling urinary catheter have the potential to be affected by the alleged deficient practic. An audit was completed of the identified resident's records to ensure that catheters had been changed and/or were scheduled to be changed in accordance to current physician order and plat of care. Nurses in serviced on 2/26/13 per SDC related to changing of catheters in accordance to physicians order. 3. Nurses in serviced on 2/26/19 per SDC related to changing of catheters in accordance to physicians' orders. Catheters where the maintained and changed per physicians' orders by DNS/designee monitoring the TAR. DNS/designee will monit by reviewing physician orders ensure catheters are changed order. DNS/Designee will ensure catheter care will be included in the residents' comprehensive plan of care.	use ed ee ed eo eo an ers. 13 will er eor to per ure	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet Page 24 of 80

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII DING	00	COMPLETED
		155148	A. BUILDING B. WING		02/07/2013
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	R			
NODTLL		ENTED		AIRWAY DR	
NORTH	PARK NURSING C	ENTER	EVAIN	SVILLE, IN 47710	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	08/31/12.				
				4. DNS /designee will comple	
	The Septembe	er 2012 TAR lacked any		catheter monitoring tool 5x we	
		the catheter had been		for 2 weeks, 3x week for 2 we	
		een 09/01/12 and		2x week for 2 weeks, then we	екіу
	. •			x 6 weeks and monthly for 3 months to ensure that cathete	are
	09/19/12. The			are changed according to	10
	handwritten notes "changed on			physicians order. Failure to	
		"Change Foley cath		comply with guidelines will res	sult
	[an indwelling	urinary catheter] on		in disciplinary action up to and	I
	09/28/12 then	q 6 weeks. due again		including termination. Results	
	Nov. 9. 2012."	The date of Nov 9,		catheter monitoring tool will b	e
		n crossed through and		monitored in QA for a minimu	
		andwritten note above		6 months, if a threshold of 95	% is
				not met an action plan will be	
		t 31st 2012." (The time		developed.	
		n catheter changes		5 Commission Date: M	avala
	equaled 6 wee	eks.)		5. Completion Date: M 9 th , 2013	arcn
				9 (11, 2013	
	A physician te	lephone order dated			
	09/19/12 indic	ated an order for			
	" change Fole	ey catheter every 6			
	weeks"	ey sameter every e			
	WCCR3				
	The Ostabar 3	012 TAD included but			
		012 TAR included, but			
		d to, an order for			
	Change Foley	catheter every month			
	and as needed	d occlusion." The entry			
	included a har	ndwritten note that			
	indicated. "cha	anged 09/19/12 and due			
		AR lacked any			
		the catheter had been			
	i changed durin	g October 2012.			
	The Nevembe	r 2012 TAD included			
		r 2012 TAR included,			
		nited to, an order for			
	Change Foley	catheter every month			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 25 of 80

	OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155148	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/07/2013
	PROVIDER OR SUPPLIER PARK NURSING CENTER	650 FA	ADDRESS, CITY, STATE, ZIP COD IRWAY DR VILLE, IN 47710	E
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE COMPLETION
	and as needed occlusion." The TAR indicated the catheter had been changed on November 9, 2012 (The time frame between catheter changes equaled 7 weeks and 2 days) A Care Plan for indwelling catheter dated 10/29/12 included, but was not limited to, an intervention of, "change catheter per MD order" During an interview on 02/05/13 at 8:30 a.m. the DoN [Director of Nursing] indicated she could provide no documentation the catheter had been changed between 08/09/12 and 09/19/12 or between 09/28/12 and 11/09/12. She further indicated, at that time, it was standard practice for the facility to change the catheter according to the Physician's orders. 3.1-35(g)(2)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 26 of 80

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLI	
		155148	B. WIN			02/07/	2013
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
NORTH I	PARK NURSING CI	ENTER			IRWAY DR VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0314 SS=D	PRESSURE SOF Based on the con a resident, the fact resident who enter pressure sores do sores unless the condition demons unavoidable; and sores receives ne services to promoting to the faction and previous developing. Based on observed review, ensure 1 of 3 sores pressure sores who met the that treatment and some infection and possure to the facility with the faction and possure for the hospit diagnoses included to the facility with the f	nprehensive assessment of cility must ensure that a sers the facility without ones not develop pressure individual's clinical strates that they were a resident having pressure accessary treatment and one healing, prevent event new sores from ervation, interview and the facility failed to ampled residents with a ninth esample of 6 reshold, received services to prevent romote healing, in that atment was not infection control not followed.	F03	14	F314 Treatment/Services to prevent / heal pressure ulcers 1.Individualized action plan initiated with RN#1 on 1/31/20 RN#1 was unable to successfue complete the requirements of individual action plan and has been terminated. Resident #9 wounds were assessed on 1/31/2013, no adverse effects noted. Resident #9 is receiving wound treatment per physician order. 2. All residents are identified to have the potential to be affected by the alleged deficient practice. Nurses in serviced on 2/20/13 SDC related to wound care including infection control practices and providing treatment orders are defined to successfully complete skills competencies to treatment/dressing changes are glucometer cleaning during orientation and at least quarter.	13. ully the g n ced se. per ent ses / for nd	03/09/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 27 of 80

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDDIG	00	COMPL	ETED
		155148	A. BUI B. WIN	LDING		02/07/	2013
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹					
NODTU	PARK NURSING C	ENTED			IRWAY DR SVILLE, IN 47710		
NORTH	PARK NURSING C	ENIER		EVANS	SVILLE, IN 477 IO		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	ischium [lower	buttock/upper thigh]			thereafter. All residents with		
	and had been	treated at home with			pressure ulcers had wound		
	home health and a wound care clinic prior to admission.				treatments observed by		
					DNS/designee to ensure	٨	
					physician orders were followed	u.	
	The clinical red	ord included					
					1.Nurses in serviced on 2/20)/13	
	physician's orders, dated 1/30/13, as				per SDC related to wound car	е	
	follows:				including infection control		
		chial wound, flush [with]			practices and providing treatm		
	NS [normal saline] cleanse surrounding [with] NS, pat dry, skin				as ordered per physician. Nurs		
					will be required to successfully		
	prep surroundi	ng tissue, apply Santyl			complete skills competencies		
	Idebriding age	nt to eliminate necrotic			treatment/dressing changes a	na	
		otic tissue, pack wound			glucometer cleaning during orientation and at least annual	llv	
	_	AG cut to size, cover			thereafter. DNS/Designee will	пу	
					conduct rounds to ensure the		
		ecure [with] Meplex			pressure ulcer treatments are		
	foam dressing	BID [twice a day]			completed per physician order	S.	
	2) (R) inner bu	uttock wound, (R)			4.DNS/ designee will complete	۵.	
	, , ,	(L) gluteal wound to be			skills competencies during	•	
	_	NS, pat dry, skin prep			treatments and/or dressing		
					changes with nurses 5x week	for	
		ssue, hydrogel [gel to			2 weeks, 3x week for 2 weeks		
		ng] applied to wound			week for 2 weeks, then weekly	/ X	
		ed meplex foam			6 weeks and monthly for 3		
	dressing BID."				months to ensure residents	- 4-	
					receive treatment and services		
	The following a	assessments of the			prevent infection and promote healing. Failure to comply with		
	_	s were in the electronic			guidelines will result in	1	
	medical record				disciplinary action up to and		
		nd Skin Evaluations,			including termination. Results	of	
		n 1/30/13 at 8:12 a.m.:			skills competencies will be		
					monitored in QA for a minimur		
	"L [left] buttock	•			6 months, if a threshold of 95%	∕₀ is	
	Present on adr	,			not met an action plan will be		
	Date originally				developed.		
	Stage II [partia	I thickness loss of					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	
		155148	B. WING	i		02/07/	2013
NAME OF D	PROVIDER OR SUPPLIER		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			650 FAI	RWAY DR		
	PARK NURSING C	ENTER		EVANS'	VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	,	u	DATE
	-	ting as a shallow open			5. Completion Date: March 9 t 2013	ın ,	
		d pink ulcer bed without			2010		
	slough]						
	Granulation						
	3.3 [centimeter	=					
	min [minimum] 	serous drainage					
	"R [right] inner buttock" documented						
	1/30/13 8:16 a						
	Present on adr	mission, no					
	Date originally						
	Stage II	,					
	Granulation						
	1.0 X 1.0 X 0.1						
	red granulation						
	min serous dra						
		ago					
	"R [right] butto	ck/gluteal" documented					
	1/30/13 8:22 a						
	Present on adr						
	Date originally	·					
	Stage II	 					
	Granulation						
	inner: 0.8 X 1.	0 X <0.1cm					
	[centimeters]						
	outer: 0.7 X 1.	2 X <0 1 cm					
	pink granulatio						
	min/scant sero						
		ao aramago					
	Measurements	of the left ischium					
	area were doci	umented on 1/28/13 as					
	follows:						
	left ischial						
		m X 6.0 cm, moderate					
		anguinous, slight odor,					
	CAUGAIC, SCIUS	angunous, siignt ouor,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet Page 29 of 80

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/12/2013 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155148	A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMPL 02/07/	ETED
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE RWAY DR VILLE, IN 47710	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	slough, slough	ed color with yellow 50%, granulation 50%, clock measuring 6 cm. distinct/defined					
	Data Set [MDS 12/27/12, indic for Mental Stat 15, indicating r impairment. The total assistance mobility, extension mobility, extension MDS had an unhealed IV [full thickness exposed bone, Slough or esch some parts of includes under The dimension MDS indicated cm wide and 5 granulation tiss. The resident's 1/7/13, for impaincluded, but we following: Treatment as on Assess for pair Assess wound.	the resident required to of two staff for bed sive assist of two for sing and hygiene. The sindicated the resident to pressure ulcer stage as tissue loss with tendon, or muscle. For armay be present on the ulcer bed. Often mining and tunneling]. It is at the time of the sit was 2.4 cm long, 1.0 and the sue. Care plan, dated the present on the deep with the sue.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 30 of 80

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155148	B. WIN	G		02/07/2013
NAME OF D	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUFFLIER			650 FAI	RWAY DR	
NORTH F	PARK NURSING C	ENTER		EVANS	VILLE, IN 47710	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE	DATE
		ident to eat at least				
	75% of meals					
	Incontinent car					
	Labs as ordered					
	Notify MD [medical doctor] of					
	worsening or no change in wound or					
	for signs of infection					
	Observe for sig					
	infectiondesc					
		dietitian] to assess				
	routinely					
	Supplements as ordered					
	Treatment as ordered					
		q [every] 2h [hours]				
	_	resident to limit time				
	_	nair] to 2 hour intervals				
	Wound healing	vitamins as ordered				
	On 1/31/13 at	10:38 a.m., RN #1 and				
	CNA #1 were of	bserved to provide				
	treatment to Re	esident #9. No				
	dressing was in	n place at that time.				
	The resident w	as observed to have				
	one large area	on the left ischium, at				
	I -	e, with significant				
	depth, not mea	sured at that time,				
	does have som	ne yellow slough in the				
		ne area below that one				
	had irregular e	dges, approximately				
	2.5 cm by 2 cm	•				
	1	me yellow slough.				
	One area on lo	· ·				
		n 1 cm by 1 cm, had				
		some yellow slough.				
	•	•				
	One more area	on the right side of				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 31 of 80

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155148	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	e survey pleted 7/2013
	PROVIDER OR SUPPLIEF		650 FA	ADDRESS, CITY, STATE, ZIP IRWAY DR VILLE, IN 47710	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
		erved 1 cm by 1 cm, small amount of yellow				
	right side as fa nurse took a sr saline and pou	ne resident over on her r as she could. The mall bottle of normal red it over the ocks and areas.				
	[debriding ager tissue] and exp a gauze pad. So ointment onto the the coccyx, left buttock areas. amount of San areas, not just areas. She ap all three areas pad and Santy clean gauze par each area. Sh Santyl on the releft ischial area large ischial area large ischial area large ischial area skin around all applied two lar- cover the areas	-				
	•	with the Director of 1/13 at 11:50 a.m., she				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 32 of 80

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCT 00	TION	(X3) DATE COMPL	
		155148	A. BUILDING B. WING			02/07	/2013
	PROVIDER OR SUPPLIEF		650	EET ADDRESS, FAIRWAY I ANSVILLE, I			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC	X (EACH CROSS-	PROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BI REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	only on the nec have been use necrotic areas hydrogel shoul	cantyl should be put crotic tissue and should ad on the large wound as ordered. The d have been used on unds as ordered.					
	dated 1/2010 a was provided to Nurses on 2/7/ procedure including the following the fo	and physician orders y and explain eld to ensure easy blies essing s and discard					
	physician orde "Wound care re a) Cleanse aw from the wound b) Cleanse fro outward c) Cleanse in d) Use a sepa each cleansing e) If drain pres	equirements: vay debris or drainage d m center of wound one direction rate swab/gauze for					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 33 of 80

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/12/2013 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148		00	COMPI - 02/07	ETED
	PROVIDER OR SUPPLIER PARK NURSING CENTER	650 FAI	ADDRESS, CITY, STATE, ZIP COI IRWAY DR VILLE, IN 47710	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	moving outward f) Measure wound as needed" Remove gloves and discard Perform hand hygiene Put on gloves Apply new dressing according to the physician orders 3.1-40(a)(2)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 34 of 80

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155148	B. WIN			02/07/	2013
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L.			RWAY DR		
NORTH F	PARK NURSING C	ENTER			VILLE, IN 47710		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT	ГЕ	
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0315 SS=D	483.25(d) NO CATHETER, BLADDER Based on the res assessment, the resident who ente indwelling cathete the resident's clin that catheterization resident who is in receives appropri to prevent urinary restore as much in possible. Based on inter review, the fact resident with an catheter receiv to the Physicia residents revies indwelling urina sample of 3, dir changed accor order. (Resider Findings include The clinical receivance was reviewed of p.m. The Physician dated 08/09/12	PREVENT UTI, RESTORE ident's comprehensive facility must ensure that a ers the facility without an er is not catheterized unless ical condition demonstrates on was necessary; and a accontinent of bladder rate treatment and services or tract infections and to normal bladder function as view and record fility failed to ensure a on indwelling urinary ed services according on's order, in that, 1 of 1 wed for having an ery catheter, in a d not have the catheter ding to the Physician's ont #B) de: cord of Resident #B on 01/30/13 at 1:58 Admission Orders et included, but was not	F03	TAG	(EACH CORRECTIVE ACTION SHOULD BE	, use ed ee. ed o an	O3/09/2013
	limited to, the "change f/c [i	following order ndwelling urinary ery] month et [and] prn			per SDC related to changing of catheters in accordance to physicians' orders. Catheters to be maintained and changed per physicians' orders by DNS/designee monitoring the	will	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet Page 35 of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	I DDIG	00	COMPL	ETED
		155148		LDING		02/07/	/2013
		1	B. WIN		ADDRESS CITY STATE TO SORE		
NAME OF I	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE		
NODTH		SENTED			IRWAY DR		
NORTH	PARK NURSING (JENTER		EVANS	VILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					TAR. DNS/designee will moni		
	The August 20	012 TAR [Treatment			by reviewing physician orders		
	Administration Record] lacked any				ensure catheters are changed		
		n the catheter had been			order. DNS/Designee will ens		
					catheter care will be included	in	
	-	reen 08/09/12 and			the residents' comprehensive		
	08/31/12.				plan of care.		
					4. DNS /designee will complet	· _	
	The September	er 2012 TAR lacked any			catheter monitoring tool 5x we		
	documentation	n the catheter had been			for 2 weeks, 3x week for 2 we		
	changed betw	reen 09/01/12 and			2x week for 2 weeks, then we		
	_	e TAR included			x 6 weeks and monthly for 3	•	
		otes "changed on			months to ensure that cathete	rs	
		•			are changed according to		
		"Change Foley cath			physicians order. Failure to		
	-	urinary catheter] on			comply with guidelines will res		
		n q 6 weeks. due again			in disciplinary action up to and		
	Nov. 9, 2012.'	' The date of Nov 9,			including termination. Results		
	2012 had bee	n crossed through and			catheter monitoring tool will be monitored in QA for a minimul		
	an undated, h	andwritten note above			6 months, if a threshold of 959		
	-	t 31st 2012." (The time			not met an action plan will be	/0 IS	
		n catheter changes			developed.		
		•			ao roiopou.		
	equaled 6 wee	eks.)			5. Completion Date: Ma	arch	
	.				9 th , 2013		
		lephone order dated					
	09/19/12 indic	ated an order for					
	"change Fol	ey catheter every 6					
	weeks"						
	The October 3	2012 TAR included, but					
		d to, an order for					
		•					
	_	y catheter every month					
	and as needed occlusion." The entry						
	included a hai	ndwritten note that					
	indicated, "changed 09/19/12 and due						
		AR lacked any					
		n the catheter had been					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148			(X2) MU A. BUIL		NSTRUCTION 00	(X3) DATE : COMPL	ETED
		155148	B. WING		DDDEGG GITTU GTATE JID GODE	02/07/	2013
NAME OF I	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP CODE		
NORTH	PARK NURSING C	ENTER			VILLE, IN 47710		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	changed durin	g October 2012.					
	The November but was not line "Change Foley and as needed indicated the continue frame being equaled 7 week." A Care Plan for dated 10/29/12 limited to, an in "change cath." "change cat	r 2012 TAR included, nited to, an order for y catheter every month d occlusion." The TAR catheter had been ovember 9, 2012 (The tween catheter changes eks and 2 days) or indwelling catheter 2 included, but was not					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet Page 37 of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155148				02/07/	2013
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	8					
NODTU		TNITED			RWAY DR		
NORTH	PARK NURSING CI	ENTER		EVANS	VILLE, IN 47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0329	483.25(I)						
SS=D	DRUG REGIMEN	IS FREE FROM					
	UNNECESSARY	DRUGS					
		rug regimen must be free					
		y drugs. An unnecessary					
		when used in excessive					
		uplicate therapy); or for					
		on; or without adequate					
		hout adequate indications					
		ne presence of adverse					
	•	hich indicate the dose					
		ed or discontinued; or any he reasons above.					
	combinations of t	ne reasons above.					
	Rased on a comm	prehensive assessment of a					
	-	ity must ensure that					
		ve not used antipsychotic					
		en these drugs unless					
	•	g therapy is necessary to					
		ondition as diagnosed and					
	-	e clinical record; and					
	residents who us	e antipsychotic drugs					
	receive gradual d	lose reductions, and					
		entions, unless clinically					
		n an effort to discontinue					
	these drugs.						
	Based on obse	ervation, interview, and	F03	29	F329 Drug regimen is free from	n	03/09/2013
	record review,	the facility failed to			unnecessary drugs		
	ensure medica	tions administered for			1.Resident #63 seen by nurs		
		an assessment of pain			practitioner on 2/1/13, new ord	ers	
	•	re monitored for			received related to pain		
	•				management. Resident #32	341-	
		or 1 of 10 residents			medication regimen reviewed	with	
	,	and failed to ensure			physician for possible dose		
	anti-anxiety, ar	nti-depressant, and			reduction, adjustments made a	15	
	anti-psychotic i	medications were			indicated.		
		gradual dose reduction			2.All residents have the potent	ial	
		dents (Resident #32)			to be effected by the alleged	iai	
		,			deficient practice. Residents		
	reviewed for ur	-			have been assessed for pain.		
	medications, in	the sample of 10 who			Those residents experiencing		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet Page 38 of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	00		00	COMPLETED	
		155148	A. BUILDING		- ,	02/07/	′2013
		1.001.10	B. WIN			0=/01/	
NAME OF I	NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					IRWAY DR		
NORTH	PARK NURSING C	ENTER		EVANS	SVILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	met the criteria	ı. (Resident #63,			pain have been provided pain		
	Resident #32)				medication as ordered and are		
					monitored for the effectivenes	SOI	
	Findings includ	le:			pain medication. All residents receiving psychotropic medica	ation	
					are scheduled for pharmacist	ation	
	1 The elipical	record of Resident #63			review. Nurses were in-service	ed	
					on 2/18/13 per SDC regarding		
		on 01/30/13 at 11:05			utilization of pain scale, PRN	,	
		rd indicated the			medication administration and		
	diagnoses inclu	uded, but were not			follow-up evaluation for		
	limited to, PVI	D [Peripheral Vascular			effectiveness of medication		
	Diseasel, chro	nic venous stasis, and			administered. Nurses were in		
	neuropathy.				serviced on 2/26/13 per SDC		
	nouropatry.				related to addressing pharma	СУ	
	Decident #62 v	vee absenced on			recommendations and		
		vas observed on			considering gradual dose		
		:30 a.m. lying in bed.			reduction to avoid unnecessar	ſy	
	During an inter	view at that time,			medications.	_	
	Resident #63 in	ndicated he			3. Nurses were in-serviced or	1	
	occasionally ex	kperienced pain.			2/18/13 per SDC regarding utilization of pain scale, PRN		
	,				medication administration and	l	
	The most recei	nt Quarterly MDS			follow-up evaluation for	ı	
		a Set Assessment]			effectiveness of medication		
	l -	-			administered. Assessments w	ill	
		3 indicated Resident			be completed prior to the		
	#63 had no co	gnitive impairment.			administration of PRN medica	tion	
					and an evaluation by licensed		
	The February 2	2013 Physician's Order			staff will be completed. Nurse		
	Recap included	d, but was not limited			were in serviced on 2/26/13 p	er	
	·	ted 09/25/12 for			SDC related to addressing		
		min [Lortab] [a narcotic			pharmacy recommendations a	and	
	pain medicatio				considering gradual dose	5 1/	
	· ·	- 0			reduction to avoid unnecessal medications. Pharmacy	У	
		ke one tablet po [by			recommendations will be		
		[six] hours prn [as			reviewed with the physician		
	needed] for pa	in.			monthly and placed on the		
					residents' charts. Pharmacy w	/ill	
	The most recei	nt Pain Assessment			be in serviced by the corporat		
		2 indicated Resident			consultant on the gradual		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	COMPLETED	
155148 B. WING	02/07/2013	
STREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER 650 FAIRWAY DR		
NORTH PARK NURSING CENTER EVANSVILLE, IN 47710		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY	COMPLETION	
in a constraint straint and a constraint y	DATE	
#63 was interviewable and reduction schedule for psychotropic medications. Social		
experienced moderate pain		
occasionally r/t [related to] BLE review monthly for psychotropic		
[Bilateral Lower Extremity] stasis medications including the date of		
ulcers. the last gradual dose reduction.		
Information will be reviewed by		
The January 2013 MAR [Medication the IDT for recommendations to		
Administration Record indicated the clinician. 4.DNS/designee w		
Resident #63 received Lortab prn on complete the pain management monitoring tool 5x week for 2	`	
01/01/13 (twice), 01/02/12, 01/04/13, weeks, 3x week for 2 weeks, 2x	(
01/06/13, 01/07/13, 01/10/13, week for 2 weeks, then weekly		
01/11/13, 01/15/13, 01/16/13, 6 weeks and monthly for 3		
01/17/12 01/19/12 01/21/12 months. DNS/ designee will		
complete the uninecessary		
01/22/13, 01/24/13, 01/25/13, medication monitoring tool 5x		
01/28/13, 01/29/13, and 01/30/13. week for 2 weeks, 3x week for 2 weeks, 2x week for 2 weeks, the		
weekly v.6 weeks and monthly f		
The Nurse's medication notes 3 months to ensure that gradual		
indicated Resident #63 had Lortab dose reductions are considered		
administered on 01/01/13 at 1600 and addressed. Failure to comp	ply	
[4:00 p.m.] The nurses medication with guidelines will result in		
note lacked any documentation that disciplinary action up to and including termination. Results of	f	
Lortab had been administered or the pain management monitorin		
monitored a second time on 01/01/13.	_	
monitoring tool will be completed		
The Lortab count sheet for the time monthly and monitored in QA fo	or	
period of 12/09/12 through 02/05/13 a minimum of 6 months. 5.		
indicated a Lortab had been Completion Date: March 9 th ,		
administered between 01/01/13 at		
1600 [4:00 p.m.] and 01/02/13 0210		
[2:10 a.m.]		
[2.10 d.m.]		
A Nurse's medication note dated		
01/07/13 at 0800 [8:00 a.m.] indicated		
Resident #63 received Lortab for "c/o		
[complaint of] pain all over, arthritic."		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet Page 40 of 80

NAME OF PROVIDER OR SUPPLIER NORTH PARK NURSING CENTER (X4) ID PREFIX TAG The note lacked any documentation of pain intensity or follow up monitoring. An untimed Nurse's medication note dated on 1/11/13 at 2200 [10:00 p.m.] A Nurse's medication note dated on 1/11/13 at 2200 [10:00 p.m.] SIREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710 STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710 (X5) PREFIX TAG PROVIDERS PLAN OF CORRECTION (X5) PROVIDERS PLAN OF CORRECTION (X5) PREFIX TAG PROVIDERS PLAN OF CORRECTION (X5) PROVIDERS PLAN OF CORRECTION (X5) PROVIDERS PLAN OF CORRECTION (X5) PROVIDERS PLAN OF CORRECTION (X5) PROVIDERS PLAN OF CORRECTION (X5) PROVIDERS PLAN OF CORRECTION (X5) PROVIDERS PLAN OF CORRECTION (X5) PROVIDERS PLAN OF CORRECTION (X5) PROVIDERS PLAN OF CORRECTION (X5) PROVIDERS PLAN OF CORRECTION (X5) PROVIDERS PLAN OF CORRECTION (X5) PROVIDERS PLAN OF CORRECTION (X5) PROVIDERS PLAN OF CORRECTION (X5) PROVIDERS PLAN OF CORRECTION (X5) PROVIDERS PLAN OF CORRECTION (X5) PROVIDERS PLAN OF CORRECTION (X5) PROVIDERS PLAN OF CORRECTION (X5) PROVIDERS PLAN OF CORRECTION (X5) PROVIDERS PLAN OF C	
NORTH PARK NURSING CENTER EVANSVILLE, IN 47710 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The note lacked any documentation of pain intensity or follow up monitoring. An untimed Nurse's medication note dated 01/10/13 indicated Resident #63 received Hydro/Acetamin 5/325 for "c/o general discomfort." The note lacked any documentation of pain intensity or follow up monitoring. A Nurse's medication note dated 01/11/13 at 2200 [10:00 p.m.]	
PREFIX TAG RECUIRCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The note lacked any documentation of pain intensity or follow up monitoring. An untimed Nurse's medication note dated 01/10/13 indicated Resident #63 received Hydro/Acetamin 5/325 for "c/o general discomfort." The note lacked any documentation of pain intensity or follow up monitoring. A Nurse's medication note dated 01/11/13 at 2200 [10:00 p.m.]	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) The note lacked any documentation of pain intensity or follow up monitoring. An untimed Nurse's medication note dated 01/10/13 indicated Resident #63 received Hydro/Acetamin 5/325 for "c/o general discomfort." The note lacked any documentation of pain intensity or follow up monitoring. A Nurse's medication note dated 01/11/13 at 2200 [10:00 p.m.]	
of pain intensity or follow up monitoring. An untimed Nurse's medication note dated 01/10/13 indicated Resident #63 received Hydro/Acetamin 5/325 for "c/o general discomfort." The note lacked any documentation of pain intensity or follow up monitoring. A Nurse's medication note dated 01/11/13 at 2200 [10:00 p.m.]	JN
indicated Resident #63 received Lortab for "c/o general pain and discomfort." The note lacked any documentation of pain intensity or follow up monitoring. A Nurse's medication note dated 01/15/13 at 1300 [1:00 p.m.] indicated Resident #63 received Lortab for "c/o shoulder pain." The note lacked any documentation of pain intensity or follow up monitoring. A Nurse's medication note dated 01/16/13 at 1400 [2:00 p.m.] indicated Resident #63 received Lortab for "c/o arthritic pain." The note lacked any documentation of pain intensity or follow up monitoring. A Nurse's medication note dated 01/17/13 at 1420 [2:200 p.m.]	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet Page 41 of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155148	B. WIN	IG		02/07/	2013
NAME OF F	PROVIDER OR SUPPLIER	₹			DDRESS, CITY, STATE, ZIP CODE		
NODTIL		ENTER			RWAY DR		
NORTH	PARK NURSING C	ENIER		EVANS	VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		dent #63 received					
		shoulder pain." The					
		y documentation of					
	pain intensity o	or follow up monitoring.					
	A Ni I	Baatlan mata data d					
		lication note dated					
		15 [2:15 p.m.] indicated					
		received Lortab for "c/o " The note lacked any					
		•					
	follow up moni	of pain intensity or					
		tornig.					
	Δ Nursa's mad	lication note dated					
		15 [10:15 p.m.]					
		dent #63 received					
		pain all over." The note					
		cumentation of pain					
	1	ow up monitoring.					
		ow up monitoring.					
	A Nurse's med	lication note dated					
		00 [1:00 p.m.] indicated					
		received Lortab for "c/o					
		" The note lacked any					
	•	of pain intensity or					
	follow up moni	•					
	.55 455	y.					
	A care plan da	ted 12/11/12 for Pain					
	1	eoarthritis included, but					
		to, interventions of,					
		e of prn medications"					
		o. pin modioationo					
	During an inter	view with the DoN					
		rsing] on 02/05/13 8:30					
	-	ated she could not					
	· ·	rther documentation r/t					
	Provide arry lar	and addamentation i/t	1				1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 42 of 80

			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155148	B. WIN			02/07/	2013
NAME OF P	PROVIDER OR SUPPLIEF	₹		1	DDRESS, CITY, STATE, ZIP CODE		
NODTLL		ENITED			RWAY DR		
NORTH	PARK NURSING C	ENIER		EVANS	VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION DATE
TAG		, , , , , , , , , , , , , , , , , , ,		TAG	Birtelinery		DATE
		resident's pain ow-up monitoring. She					
	1	ed, at that time, when					
		lications, the nursing					
		sess the intensity of					
	the pain and m	-					
	•	of the medication.					
	01100017011000	i alo modiodioni.					
	A policy and p	rocedure for Pain					
		provided by the DoN on					
		50 a.m. indicated, "2.					
		e residentgiven based					
		sity of the pain7.					
	I -	rmation including, but					
	not limited to re	•					
	administration,	interventions, and					
	effectiveness of	of pain medication will					
	be documented						
	2. Resident #3	32 was observed to be					
	sleeping in a c	hair in the activity area					
	on 1/30/13 at 1	l1:00 a.m. The					
	resident was o	bserved to be in a					
	dining/activity	area for exercise					
	activity. She w	as very sleepy looking,					
	and not partici	pating in the activity. At					
		1/31/13, the resident					
	was observed	in her room in her chair					
	sound asleep.						
		clinical record was					
		31/13 at 10:10 a.m.					
		as admitted to the					
		/11 with diagnoses					
	including, but r	not limited to,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 43 of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155148	B. WIN	IG		02/07/	2013
NAME OF I	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	KO VIDEK OK SUI I EIEI	X.		650 FAI	RWAY DR		
NORTH	PARK NURSING C	ENTER		EVANS'	VILLE, IN 47710		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ychosis, anxiety state,					
	•	euralgia, hypertension, congestive heart failure,					
	1 ,	ar disease, and					
	arthropathy.	ai disease, aild					
	artinopatriy.						
	The physician's	s orders, signed					
		led, but were not limited					
	to, the followin	g:					
	Alprazolam [ar	ntianxiety] 0.25 mg 1					
	(one) po daily	at bedtime "hold for					
	sedation" since	e 7/15/11					
	Lexapro [antide	epressant] 20 mg po					
	daily						
	Risperidone [a	ntipsychotic] 0.25 mg					
	one twice a da	y since 8/25/11					
	Resident #32's	s annual Minimum Data					
	Set [MDS] ass	essment, dated					
		ited the resident was					
	•	ntianxiety medication					
	_	pressant medication but					
		te the resident was					
	receiving an ar	ntipsychotic medication.					
		s quarterly MDS, dated					
		cated the resident was					
		ntianxiety medication					
	•	pressant, but failed to					
		sident was receiving an					
	antipsychotic n	nedication.					
	Resident #32 h	nad a care plan, dated					
		ng at risk for adverse					
	side effects rel	•					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet Page 44 of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155148	B. WING	_		02/07/	2013
NAME OF I	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE		
NORTH	PARK NURSING (CENTER			IRWAY DR VILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)		DATE
	psychotropic r						
	limited to, the	included, but were not					
		eds as ordered, observe					
	for effectivene						
		ment for tremors and					
	associated sig						
		medication] assessment					
	two times per	-					
	•	e effects as observed					
	and notify MD						
	Observe for si	ide effects antipsychotic					
	meds and nor	n-antipsychotic meds					
	Pharmacist to	review meds routinely					
		9:30 a.m., pharmacy					
		ions were requested					
		ctor of Nurses [DoN] for					
		for Resident #32. She port at 11:00 a.m. on					
	2/1/13, indicat						
		ions" in October and					
	November, 20						
	1	ion dated 12/11/12					
		tine artificial tears and					
		sone [nasal steroid					
		ndicated there were no					
		endations she could					
	find.						
		sing progress notes, on					
		p.m., indicated the					
	following:	na IID a aidem til a salta					
		m. "Resident hard to					
	arouse this Al	M. Wakes up then goes					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet Page 45 of 80

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/12/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE S COMPL	
MADILAN	or connection	155148		LDING		02/07/	
		100110	B. WIN		DDDEGG CITY OTHER OTH CORE	32/01/	
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
NORTH F	PARK NURSING CI	ENTER			VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		Awaken constantly		TAG	BETTOERNOT		DATE
	-	st and reminded to eat.					
	_	d eat when fed by					
	staff"	a cat which led by					
	ota						
	On 2/5/13 at 1:	05 p.m., the resident					
		on the unit, seated on					
	a couch. Her e	eyelids were drooping.					
	3.1-48(a)(3)						
	3.1-48(b)(2)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 46 of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			f '				X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED	
		155148	B. WIN		02/07/2013		2013	
	PROVIDER OR SUPPLIER PARK NURSING CI			650 FA	ADDRESS, CITY, STATE, ZIP CODE IRWAY DR SVILLE, IN 47710		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
F0363 SS=D	ADVANCE/FOLL Menus must mee residents in accorrecommended die Food and Nutritio Research Counci Sciences; be prefollowed. Based on obserecord review, ensure recipes 6 pureed diets, spaghetti sauca according to th (Residents #1, #52) Finding include Cook #1 was opureed spaghet 10:20 a.m. Shopreparing for 11 consulting a respaghetti sauca placed 1 quart into the procestablespoon of the poured it into a indicated she werequested for herecipe. The recagain at that tirestands and succession of the recipe. The recagain at that tirestands and succession of the recipe. The recagain at that tirestands are succession of the recipe. The recagain at that tirestands are succession of the recipe. The recagain at that tirestands are succession of the recipe. The recagain at that tirestands are succession of the recipe. The recagain at that tirestands are succession of the recipe.	t the nutritional needs of rdance with the etary allowances of the n Board of the National I, National Academy of pared in advance; and be ervation, interview and the facility failed to were followed for 6 of in that the amount of e pureed was not e recipe. #10, #17, #93, #57, es: bserved preparing etit sauce on 2/1/13 at e indicated she was 0 servings and was cipe for pureed e for 10 servings. She and 3/4 cup of sauce sor. She then added 1	F03	63	F363 Menus meet res needs/ prep in advance/follow 1. The amount of spaghetti sauce needed, according to the recipe, was added to the pureed food prior being served to the residents. Recipes are being followed who preparing pureed foods. 2. All residents has the potential to be effected by alleged deficient practice. Diet staff was in serviced on 2/8/13 per CDM related to preparing puree diets and following recipes are being followed who preparing pureed foods. 3. Dietary staff was in service on 2/8/13 per CDM related to preparing pureed foods. 3. Dietary staff was in service on 2/8/13 per CDM related to preparing pureed foods. 4. Dietary staff was in service on 2/8/13 per CDM related to preparing pureed foods. 5. Dietary staff was in service on 2/8/13 per CDM related to preparing pureed foods. 6. Dietary staff was in service on 2/8/13 per CDM related to preparing pureed foods. 7. Dietary staff was in service on 2/8/13 per CDM related to preparing pureed foods. 8. Dietary staff was in service on 2/8/13 per CDM related to preparing pureed foods. 9. Dietary staff was in service on 2/8/13 per CDM related to preparing pureed foods.	to nen ave the ary ses. nen d	03/09/2013	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 47 of 80

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING O0 COMPLETED	ED
B. WING	
STREET ADDRESS CITY STATE 7ID CODE	013
NAME OF PROVIDER OR SUPPLIER NORTH PARK NURSING CENTER STREET ADDRESS, CHT, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COUNTY OF THE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
added. She then added the additional 3/4 quart of sauce and finished the process. The recipe was provided by the Dietary Service Manager on 2/7/13 at 10:44 a.m. The recipe indicated for 10 servings the amount of spaghetti meat sauce was to be "1 3/4 Quart 1/2 Cup." Review of the Nurse Aide Assignment sheets on 2/1/13 at 11:00 a.m., provided by the Director of Nurses on 1/28/13 at 10:55 a.m., indicated the following residents received puree diets: Residents #1, #10, #17, #93, #57, #52. 3.1-20(i)(4)	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 48 of 80

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII	DDIG	00	COMPLETED	
		155148	A. BUII B. WIN			02/07/	2013
			B. WIN		ADDRESS STATE STATE STATE		
NAME OF P	ROVIDER OR SUPPLIER	_			ADDRESS, CITY, STATE, ZIP CODE		
					IRWAY DR		
NORTHE	PARK NURSING CE	ENTER		EVANS	VILLE, IN 47710		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	BROWING BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
F0364	483.35(d)(1)-(2)	•					
SS=D	NUTRITIVE VALU	JE/APPEAR.					
	PALATABLE/PRE						
		eives and the facility					
		pared by methods that					
	•	value, flavor, and					
	appearance; and	food that is palatable,					
	attractive, and at	the proper temperature.					
	Based on obse	rvation, interview and	F03	64	F364 Nutritive value/appear,		03/09/2013
		the facility failed to			palatable/prefer temp		
		rved was palatable			·		
		•			1. Food is being served at		
		er temperature, for 3			palatable temperatures		
	•	esidents in a sample of			CDM/designee monitoring the		
	6 who met the	threshold.			temperatures at each meal in		
	(Resident #140), Resident #141,			each dining room and monitori	ng	
	Resident #142))			room trays temperatures.		
	,	•					
	Findings includ	۵:			1.All residents have the		
	i iliuliigs iliciuu	С.			potential to be effected by the		
					alleged deficient practice. Diet	-	
	• •	survey confidential			staff were in serviced on 2/28/ per CDM related to food	13	
	resident intervi	ews, the following			temperature and documentation	nn.	
	information was	s provided:			protocol. CDM/ designee will	711	
	Resident #140	indicated on 1/28/13 at			monitor the temperatures at ea	ach	
		food he received was			meal in each dining room and	2011	
	•	astes like junk, wouldn't			monitoring the room tray		
	•	-			temperatures. Insulated bowls	will	
	•	og." Resident #141			be used to ensure food is serv		
	indicated, on 1/	/29/13 at 9:27 a.m., the			at appropriate warm temperatu		
	food was never	r hot, "lukewarm is the					
	best I can give	you." Resident #142			3. Dietary staff were in service	ed	
	•	29/13 at 9:12 a.m. the			on 2/28/13 per CDM related to		
		when she received it.			food temperature and		
	IOOU WAS COIU V	which she received it.			documentation protocol. Food		
	T				temperatures will be obtained		
	•	e was observed on			the food line and the last hall to	ray	
	2/1/13 beginnir	ng at 7:28 a.m. At that			to ensure food is served at		
	time, the first ca	art was sent to			appropriate temp. The DM will		
	·	age, the Alzheimer's			review the food temperatures t		
	, lagable 5 Coll	ago, alo mallollilo o			ensure safe and palatable food	d is	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet Page 49 of 80

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION 00	(X3) DATE COMPL	
		155148	A. BUILDING B. WING		02/07/	/2013
	PROVIDER OR SUPPLIEI		650	ET ADDRESS, CITY, STATE, ZIP CODE FAIRWAY DR NSVILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	served at 8:05 were checked scrambled egg	a. The last tray was a.m. Temperatures at that time. The ps measured 90 elt cool to touch.		served. CDM/designee will conduct resident interviews during meals to ensure res satisfaction with food temp and taste.	s ident	
	sent out at 7:3 the trays had be residents were Resident #142 warmer than u Residents #14 the A hall and 8:05 a.m. on 2 their food was "ok today" [#14 On 02/01/13 as documented to eggs on the storeviewed in the were 185 degrees	t 10:30 a.m., the emperatures of the eam table were e kitchen. The eggs ees Fahrenheit on the for to service, according		4. DM/designee will co meal service observation to week for 2 weeks, 3x week weeks, 2x week for 2 week weekly x 6 weeks and mor 3 months to ensure that for served at the proper temper Results of meal service observation tool will be modern in the monthly CQI meeting minimum of 6 months; if a threshold of 95% is not meaction plan will be develop 5. Completion Damarch 9 th, 2013	ool 5x for 2 s, then thly for od is erature. nitored g for a t an ed.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 50 of 80

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155148	B. WIN			02/07/	2013
			В. W II.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				IRWAY DR		
NORTH F	PARK NURSING C	ENTER			SVILLE, IN 47710		
					1		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
F0371	483.35(i) FOOD PROCURI	-					
SS=F		E, RE/SERVE - SANITARY					
	The facility must						
		from sources approved or					
		actory by Federal, State or					
	local authorities;	and					
		e, distribute and serve food					
	under sanitary co						
		rvation, interview and	F03	71	F371 Food procure,		03/09/2013
		the facility failed to			store/prepare/serve		
	ensure the dish	nwasher water			The dishwasher temperature or meeting the required.	es	
	temperatures v	vere monitored to			are meeting the required specification for sanitizing dish	201	
	ensure tempera	atures met the required			by purchasing and installing a	103	
	•	or sanitization of			new thermostat and high limit		
	dishes, for 1 of				switch in the water heater boo	ster	
	•	the facility. This had			to ensure the water is at		
		affect 94 residents			appropriate temperature.		
	•	ood from the kitchen.					
	wild received it	ood from the kitchen.					
					2. All residents have the		
	Finding include	: S.			potential to be effected by the		
					alleged deficient practice. Diet	arv	
	On 2/1/13 at 10				staff were in serviced 2/8/13 p	•	
		s observed running.			CDM related to dishwasher		
	Dietary Aide #1	I was observed in the			temperature monitoring. Three	÷	
	dish room. At	hermometer gauge			times daily the water		
	was observed	below the dishwasher.			temperatures are checked and		
	An attempt was	s made to read the			the temps are logged. This log monitored by Dietary	IS	
	•	ture. Dietary Aide #1			Manager/Designee daily.		
	•	nermometer did not			managen beeignee daily.		
		ated he had to check			3. Dishwasher temps will be		
		ooster heater every			obtained and documented on	the	
	third wash. He	_			dishwasher temperature log to	be	
					reviewed by the DM. Dietary		
	•	was supposed to be			Manager/Designee will monito	r	
		le of the machine. He			the log daily. If temps are not appropriate, appropriate action	,	
	brovided a doc	umentation book			will be taken.	•	
			1		1		I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 51 of 80

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/12/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155148	B. WIN	G		02/07/2	2013
NAME OF P	PROVIDER OR SUPPLIEF	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					IRWAY DR		
NORTH F	PARK NURSING C	ENTER		EVANS	VILLE, IN 47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	· ·	peratures were			4.DM/ designee will complete		
	documented.				sanitation tool 5x week for 2		
					weeks, 3x week for 2 weeks, 2	2x	
		res were documented			week for 2 weeks, then weekly	y x	
	1	/13 through 2/1/13 on			6 weeks and monthly for 3		
	. •	e was temperature was			months to ensure that dishwar	II	
		s 120 degrees, the			temperatures meet the require specifications for sanitization		
		ure was documented			dishes. Results of infection	-	
	_	s and the sanitizer			control tool will be reviewed in	the	
	concentration v	was documented as 75			monthly CQI meeting for a		
	parts per millio	n. Dietary Aide #1			minimum of 6 months; if a	_	
	indicated he di	d not have a			threshold of 95% is not met an action plan will be developed.	1	
	functioning the	rmometer to check the			delight plan will be developed.		
	temperature bu	ut knew it was hot			5. Completion Date:		
	enough by feel	 He indicated the 			March 9 th , 2013		
	people who ins	stalled the dishwasher					
	had told him to	write down 120 and					
	140 degrees in	the book.					
	At 10:50 a.m. o	on 2/1/13, water					
	temperatures v	vere checked as water					
	came out of the	e dishwasher. The					
	maximum tem	perature reached on					
	the first run wa	s 96 degrees during					
	the wash and	109 degrees during the					
	rinse cycle. O	n the second run, the					
	maximum tem	perature reached was					
	110 degrees o	n the wash cycle and					
	_	n the rinse cycle. The					
		chine indicated the					
	minimum wash	and rinse temperature					
		degrees and 140					
		ecommended. The					
		chemical sanitation.					
		concentration was					
	1 5		1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 52 of 80

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155148	B. WIN			02/07/	2013
NAME OF F	PROVIDER OR SUPPLIER	}		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					RWAY DR		
NORTH I	PARK NURSING C	ENTER		EVANS	VILLE, IN 47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	cnecked and w	vas as recommended.					
		1:00 a.m., the Dietary					
	_	informed of the					
		not reaching the					
		levels. She indicated					
		are the thermometer					
		n the side of the					
		ne Dietary Manager					
	indicated the a	ctual temperature of					
	the water shou	ıld be checked and					
	written down.						
	The temperatu	re of the water during					
		e cycle was rechecked					
	at 11:05 a.m. a	and it reached a					
	temperature of	f 153 degrees.					
	The Dietary Ma	anager indicated at that					
	time she was h	naving the company					
	who serviced t	he equipment come out					
	and check it ou	ut.					
		ator indicated on 2/6/13					
	at 2:00 p.m., re	•					
		e company came in					
		the dishwasher and					
	indicated the b	ooster needed a new					
	thermostat; this	s was causing it to shut					
	off on occasior	n causing an					
	inconsistency i	in temperatures.					
	Temperatures	were now being					
		sure water reached					
	appropriate lev	vels and the new					
	1	s being overnighted.					
	ı ınermostat wa:	s being overnighted.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet Page 53 of 80

	OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE (COMPL	
		155148	A. BUII B. WIN	LDING G		02/07/	2013
NAME OF I	PROVIDER OR SUPPLIER		P		ADDRESS, CITY, STATE, ZIP CODE		
					RWAY DR		
	PARK NURSING CI			<u> </u>	VILLE, IN 47710		715
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	and revised 04 the Dietary Ser 2/7/13 at 10:44 procedure includimited to, the form of the procedure includimited to, the form of the procedure includimited to, the form of the procedure including the procedure including the procedure and procedure and the staff to the procedure temperature of the procedure including	Machine Sanitizer, dated 02/02 /11, was provided by rvice Manager on Fa.m. The policy and uded, but was not sollowing: Staff will monitor and schine temperatures or concentration to sanitizing of dishes. rvices Manager will to be posted near the or Services manager will or monitor the dish teratures throughout the or coess. trained to record dish teratures for the wash tes and the sanitizer (if appropriate) at each or Services Manager will the services Man					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 54 of 80

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/12/2013 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER NORTH PARK NURSING CENTER (X4) ID PREFIX TAG 6. The Dietary Services Manager will promptly assess any dish machine problems and take corrective action to assure appropriate sanitization of dishes." 3.1-21(i)(2)		OF CORRECTION	IDENTIFICATION NUMBER: 155148	A. BUII B. WIN	LDING	00	COMPL 02/07/	ETED
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 6. The Dietary Services Manager will promptly assess any dish machine problems and take corrective action to assure appropriate sanitization of dishes." (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OF LSC IDENTIFYING INFORMATION) TAG PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OF UNIT ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE COMPLETION DATE				P. W.	STREET A	RWAY DR		
promptly assess any dish machine problems and take corrective action to assure appropriate sanitization of dishes."	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	ΓE	COMPLETION
		6. The Dietary promptly asses problems and t to assure approdishes."	Services Manager will s any dish machine ake corrective action					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet Page 55 of 80

AND PLAN OF CORRECTION 155148	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	r .	
NAME OF PROVIDER OR SUPPLIER NORTH PARK NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES D PROVIDERS PLAN OF CORRECTION (XS)	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	DING	00	COMPLETED	
NAME OF PROVIDER OR SUPPLIER NORTH PARK NURSING CENTER (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FO412 SS=D ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with \$483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, in necessary, assist the resident is making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on interview and record review, the facility failed to provide dental services to 2 of 2 residents reviewed in a sample of 9 residents who met the criteria for dental issues, in that 1 resident had loose dentures and 1 resident had loose and missing teeth. (Resident #29, Resident #111) Findings include: 1. Resident #29's record was reviewed on 1/30/13 at 2:10 p.m. Period #70/90 disensepte include but the content of the provision of the content of the provision of the content of the provision of the content of the provision of the provisio			155148				02/07/2013	
NAME OF PROVIDER OR SUPPLER (X4) ID (X4) ID (PROVIDER OR SUPPLER) (X4) ID (PROVIDER OR SUPPLER) (REACH DEFICIENCY MINT BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FO412 SS=D (ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with \$483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on interview and record review, the facility failed to provide dental services to 2 of 2 residents reviewed in a sample of 9 residents who met the criteria for dental issues, in that 1 resident had loose dentures and 1 resident had loose and missing teeth. (Resident #29, Resident #111) Findings include: 1. Resident #29's record was reviewed on 1/30/13 at 2:10 p.m. Period #70/10 diagnesses in provide of the protection of the provide			<u> </u>	D. WIIV	_	ADDRESS CITY STATE ZIP CODE		
NORTH PARK NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG MEDILATORY OR LSC IDENTIFYING INFORMATION) FO412 SS=D ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with \$483.76(n) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on interview and record review, the facility failed to provide dental services to 2 of 2 residents who met the criteria for dental issues, in that 1 resident had loose dentures and 1 resident had loose and missing teeth. (Resident #29, Resident #111) Findings include: 1. Resident #29's record was reviewed on 1/30/13 at 2:10 p.m. Point at 20's discussion of the precision of the potential to be affected by the alleged deficient practice. All residents have been asked/	NAME OF F	PROVIDER OR SUPPLIER	<u>'</u>					
(X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG RECHARCHORMETORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG RECHARCHORMETORY OR LSC IDENTIFYING INFORMATION) TAG RECHARCHORM INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFY INFORMATION TAG REGULATORY OR LSC IDENTIFY TAG REGULATORY OR LSC IDENTIFY TAG REGULATORY OR LSC IDENTIFY TAG REGULATORY OR LSC IDENTIFY TAG REGULATORY OR LSC IDENTIFY TAG REGULATORY OR LSC IDENTIFY TAG REGULATORY OR LSC IDENTIFY TAG REGULATORY OR LSC IDENTIFY TAG REGULATORY OR LSC IDENTIFY TAG REGULATORY OR LSC IDENTIFY TAG REGULATORY OR LSC IDENTIFY TAG REGULATORY OR LSC IDENTIFY TAG REGULATORY OR LSC IN TAG REGULATORY OR LSC IN TAG REGULATORY OR LSC	NORTH I	PARK NURSING C	ENTER		1			
PREFIX TAG REQUIATORY OR LSC IDENTIFYING INFORMATION) FO412 SS=D ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with \$483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on interview and record review, the facility failed to provide dental services to 2 of 2 residents reviewed in a sample of 9 residents who met the criteria for dental issues, in that 1 resident had loose and missing teeth. (Resident #29, Resident #111) Findings include: 1. Resident #29's record was reviewed on 1/30/13 at 2:10 p.m. Posident #70's disenses include, but the latest the potential to be affected by the alleged deficient practice. All residents have been asked/						T		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FO412 SS=D ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on interview and record review, the facility failed to provide dental services to 2 of 2 residents reviewed in a sample of 9 residents who met the criteria for dental issues, in that 1 resident had loose and missing teeth. (Resident #29, Resident #111) Findings include: 1. Resident #29's record was reviewed on 1/30/13 at 2:10 p.m. Point #20's disented by the alleged deficient practice. All residents have been asked/							,	
F0412 SS=D ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with \$483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on interview and record review, the facility failed to provide dental services to 2 of 2 residents reviewed in a sample of 9 residents who met the criteria for dental issues, in that 1 resident had loose dentures and 1 resident had loose dentures and 1 resident had loose and missing teeth. (Resident #29, Resident #111) Findings include: 1. Resident #29's record was reviewed on 1/30/13 at 2:10 p.m. Particlest #20's diseases include but the sident shave been asked/		`				CROSS-REFERENCED TO THE APPROPRIA	E	
ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with \$483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on interview and record review, the facility failed to provide dental services to 2 of 2 residents reviewed in a sample of 9 residents who met the criteria for dental issues, in that 1 resident had loose dentures and 1 resident had loose and missing teeth. (Resident #29, Resident #111) Findings include: 1. Resident #29's record was reviewed on 1/30/13 at 2:10 p.m. Pacident #20's diagnages include but			LSC IDENTIFYING INFORMATION)		IAG	DEI ICERCI)	DA	HE
SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on interview and record review, the facility failed to provide dental services to 2 of 2 residents reviewed in a sample of 9 residents who met the criteria for dental issues, in that 1 resident had loose dentures and 1 resident had loose and missing teeth. (Resident #29, Resident #111) Findings include: 1. Dental consents have been obtained for resident #29 and resident #111. Both residents have dental examination scheduled at this time. MDS assessments modified and submitted for residents #29 and #111. 2. All residents have the potential to be affected by the alleged deficient practice. All residents have been asked/		` '	CENCY DENTAL					
The nursing facility must provide or obtain from an outside resource, in accordance with \$483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on interview and record review, the facility failed to provide dental services to 2 of 2 residents reviewed in a sample of 9 residents who met the criteria for dental issues, in that 1 resident had loose dentures and 1 resident had loose and missing teeth. (Resident #29, Resident #111) Findings include: 1. Resident #29's record was reviewed on 1/30/13 at 2:10 p.m. Posident #70's diagrapses include but	33-D							
from an outside resource, in accordance with \$483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on interview and record review, the facility failed to provide dental services to 2 of 2 residents reviewed in a sample of 9 residents who met the criteria for dental issues, in that 1 resident had loose dentures and 1 resident had loose and missing teeth. (Resident #29, Resident #111) Findings include: 1. Resident #29's record was reviewed on 1/30/13 at 2:10 p.m. Posident #70's diagrapses include but								
extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on interview and record review, the facility failed to provide dental services to 2 of 2 residents reviewed in a sample of 9 residents who met the criteria for dental issues, in that 1 resident had loose dentures and 1 resident had loose and missing teeth. (Resident #29, Resident #111) Findings include: 1. Resident #29's record was reviewed on 1/30/13 at 2:10 p.m. Posident #20's digarneses include but								
emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on interview and record review, the facility failed to provide dental services to 2 of 2 residents reviewed in a sample of 9 residents who met the criteria for dental issues, in that 1 resident had loose dentures and 1 resident had loose and missing teeth. (Resident #29, Resident #111) Findings include: 1. Resident #29's record was reviewed on 1/30/13 at 2:10 p.m. Posident #30's digargeose include but		with §483.75(h) o	of this part, routine (to the					
needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on interview and record review, the facility failed to provide dental services to 2 of 2 residents reviewed in a sample of 9 residents who met the criteria for dental issues, in that 1 resident had loose dentures and 1 resident had loose and missing teeth. (Resident #29, Resident #111) Findings include: 1. Resident #29's record was reviewed on 1/30/13 at 2:10 p.m. Posident #29's diagrapses include but								
assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on interview and record review, the facility failed to provide dental services to 2 of 2 residents reviewed in a sample of 9 residents who met the criteria for dental issues, in that 1 resident had loose dentures and 1 resident had loose and missing teeth. (Resident #29, Resident #111) Findings include: 1. Resident #29's record was reviewed on 1/30/13 at 2:10 p.m. Posident #29's diagnoses include but								
and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on interview and record review, the facility failed to provide dental services to 2 of 2 residents reviewed in a sample of 9 residents who met the criteria for dental issues, in that 1 resident had loose dentures and 1 resident had loose and missing teeth. (Resident #29, Resident #111) Findings include: 1. Resident #29's record was reviewed on 1/30/13 at 2:10 p.m. Pocident #39's diagrapses include but								
from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on interview and record review, the facility failed to provide dental services to 2 of 2 residents reviewed in a sample of 9 residents who met the criteria for dental issues, in that 1 resident had loose dentures and 1 resident had loose and missing teeth. (Resident #29, Resident #111) Findings include: 1. Dental consents have been obtained for resident #29 and resident #111. Both residents have dental examination scheduled at this time. MDS assessments modified and submitted for residents #29 and #111. 2. All residents have the potential to be affected by the alleged deficient practice. All residents have been asked/								
refer residents with lost or damaged dentures to a dentist. Based on interview and record review, the facility failed to provide dental services to 2 of 2 residents reviewed in a sample of 9 residents who met the criteria for dental issues, in that 1 resident had loose dentures and 1 resident had loose and missing teeth. (Resident #29, Resident #111) Findings include: 1. Dental consents have been obtained for resident #29 and resident #111. Both residents have dental examination scheduled at this time. MDS assessments modified and submitted for residents #29 and #111. 2. All residents have the potential to be affected by the alleged deficient practice. All residents have been asked/								
dentures to a dentist. Based on interview and record review, the facility failed to provide dental services to 2 of 2 residents reviewed in a sample of 9 residents who met the criteria for dental issues, in that 1 resident had loose dentures and 1 resident had loose and missing teeth. (Resident #29, Resident #111) Findings include: 1. Dental consents have been obtained for resident #29 and resident #111. Both residents have dental examination scheduled at this time. MDS assessments modified and submitted for residents #29 and #111. 2. All residents have the potential to be affected by the alleged deficient practice. All residents have been asked/								
review, the facility failed to provide dental services to 2 of 2 residents reviewed in a sample of 9 residents who met the criteria for dental issues, in that 1 resident had loose dentures and 1 resident had loose and missing teeth. (Resident #29, Resident #111) Findings include: 1. Dental consents have been obtained for resident #29 and resident #111. Both residents have dental examination scheduled at this time. MDS assessments modified and submitted for residents #29 and #111. 2. All residents have the potential to be affected by the alleged deficient practice. All residents have been asked/			•					
review, the facility failed to provide dental services to 2 of 2 residents reviewed in a sample of 9 residents who met the criteria for dental issues, in that 1 resident had loose dentures and 1 resident had loose and missing teeth. (Resident #29, Resident #111) Findings include: 1. Dental consents have been obtained for resident #29 and resident #111. Both residents have dental examination scheduled at this time. MDS assessments modified and submitted for residents #29 and #111. 2. All residents have the potential to be affected by the alleged deficient practice. All residents have been asked/		Based on inter	view and record	F04	12	F412 Routine/emergency dent	al 03/09	9/2013
dental services to 2 of 2 residents reviewed in a sample of 9 residents who met the criteria for dental issues, in that 1 resident had loose dentures and 1 resident had loose and missing teeth. (Resident #29, Resident #111) Findings include: 1. Dental consents have been obtained for resident #29 and resident #111. Both residents have dental examination scheduled at this time. MDS assessments modified and submitted for residents #29 and #111. 2. All residents have the potential to be affected by the alleged deficient practice. All residents have been asked/		review, the faci	ility failed to provide			services in nfs		
reviewed in a sample of 9 residents who met the criteria for dental issues, in that 1 resident had loose dentures and 1 resident had loose and missing teeth. (Resident #29, Resident #111) Findings include: 1. Dental consents have been obtained for resident #29 and resident #111. Both residents have dental examination scheduled at this time. MDS assessments modified and submitted for residents #29 and #111. 2. All residents have the potential to be affected by the alleged deficient practice. All residents have been asked/			•					
who met the criteria for dental issues, in that 1 resident had loose dentures and 1 resident had loose and missing teeth. (Resident #29, Resident #111) Findings include: 1. Resident #29's record was reviewed on 1/30/13 at 2:10 p.m. Posident #20's diagrages include but								
in that 1 resident had loose dentures and 1 resident had loose and missing teeth. (Resident #29, Resident #111) Findings include: 1. Resident #29's record was reviewed on 1/30/13 at 2:10 p.m. Posident #20's diagrapses include but			-				-	
and 1 resident had loose and missing teeth. (Resident #29, Resident #111) Findings include: 1. Resident #29's record was reviewed on 1/30/13 at 2:10 p.m. Posident #20's diagnoses include but			·				1.	
time. MDS assessments modified and submitted for residents #29 and #111. Findings include: 1. Resident #29's record was reviewed on 1/30/13 at 2:10 p.m. Posident #20's diagnoses include but								
reviewed on 1/30/13 at 2:10 p.m. Resident #29's record was reviewed to 1/30/13 at 2:10 p.m. Posident #20's diagnoses include but							ied	
Findings include: 2. All residents have the potential to be affected by the alleged deficient practice. All residents have been asked/		l leeth. (Resider	ii #29, Resideni #111)					
2. All residents have the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. All residents have been asked/		l <u>_</u>				and #111.		
1. Resident #29's record was reviewed on 1/30/13 at 2:10 p.m. Posident #20's diagnoses include but		Findings includ	ıe:					
reviewed on 1/30/13 at 2:10 p.m. Resident #20's diagnoses include but							ne	
Posident #20's diagnoses include but		1. Resident #2	'9's record was			1 .		
I Decident #20's disappeas include but		reviewed on 1/	30/13 at 2:10 p.m.					
assessed if they need dental		Resident #29's	diagnoses include, but			assessed if they need dental		
are not limited to, bipolar disorder, services. Consents were obtained		are not limited	to, bipolar disorder,			· ·	ned	
anemia, uterine cancer, anxiety, for residents wishing to see a		anemia, uterine	e cancer, anxiety,					
chronic kidney disease, and an dentist. Facility audit completed to		chronic kidney	disease, and an					
abdominal aortic aneurysm ensure that dental consents have		·					ive	
been obtained and dental			, -				۱	
Services scheduled as indicated. The annual MDS [Minimum Data Set] IDT and nurses in serviced on		The annual MC)S. [Minimum Data Set]				u.	
assessment, dated 4/6/12, and the 2/26/13 per SDC related to dental			•				ntal	
4336331116111, 44164 175/12, 4114 1116 2723/13 55 134654 15 4511411						services.		
		ı ı ı/ ı 4 / l2. IIIQIC	aleu liie residelil liäd	- 1		3. IDT and nurses in serviced		l.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 56 of 80

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPLETED
		155148	A. BUI. B. WIN			02/07/2013
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	8		1	IRWAY DR	
NORTH F	PARK NURSING C	ENTER			VILLE, IN 47710	
	ARR NOROING O					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	·	DATE
	_	nterview for mental			2/26/13 per SDC related to de	
	status] score o	f 15 out of 15,			services. Social Service Direct will review all dental consents	
	indicating the r	esident did not have			ensure all residents are receiv	
	any cognitive in	mpairment. The			dental services as needed. An	_
	annual MDS as	ssessment, dated			refusal of consent, the Social	,
		ed Resident #29 had no			Service director will follow up	
		s. The assessment			with the resident to inquire abo	out
		e the resident had			dental services.	
		quarterly MDS, dated			4 DNIC/desisors a will as associate	4-
		-			4. DNS/designee will comple assessment monitoring tool 5x	
		not indicate any dental			week for 2 weeks, 3x week for	
	issues.				weeks, 2x week for 2 weeks, t	
					weekly x 6 weeks and monthly	
		vas interviewed on			3 months to ensure that	
	1/29/13 at 9:17	a.m. On interview the			comprehensive assessments	
	resident indica	ted she had loose			accurately reflect the residents	
	dentures. Res	ident #29 indicated her			status, including but not limited	d to
	dentures were	at least 20 years old			skin issues, psychoactive	
	and she had no	ot been to the dentist in			medications and dental status SSD/designee will complete	•
	auite some tim	e. The resident			dental service monitoring tool	5x
	· ·	nad been able to chew			week for 2 weeks, 3x week for	
		ty but probably needs			weeks, 2x week for 2 weeks, t	
		ents to her dentures.			weekly x 6 weeks and monthly	/ for
		ents to her dentales.			3 months to ensure dental	
	Intonious	SW #1 on 2/1/12 of			consents and services are	- f
		SW #1 on 2/1/13 at			provided as indicated. Results	
	•	licated the resident had			assessment monitoring tool ar dental service monitoring tool	
		al visit since being			be monitored in QA for a	******
		e facility. SW #1			minimum of 6 months, if a	
		did not realize the			threshold of 95% is not met ar	ı
	resident had a	ny dental issues. SW			action plan will be developed.	
	#1 indicated sh	ne could not locate the				
	consent for dea	ntal services that is			5. Completion Date:	
		ne resident is admitted			March 9 th , 2013	
	_	SW #1 indicated she				
	_	follow up with the				
		•				
	resident's char	ts to ensure the				

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155148	A. BUILDIN	G	00	02/07/2013	
		100110	B. WING	DEET A	DDRESS, CITY, STATE, ZIP CODE	02/01/2010	
NAME OF P	PROVIDER OR SUPPLIER				RWAY DR		
	PARK NURSING CI	ENTER			VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREI TA		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
		heir consents signed					
		d she would speak with					
		amily to allow the					
	resident to hav	e a dental					
		SW #1 indicated the					
		be visited by a dentist					
	•	the resident could visit					
	their own denti	Sī.					
	Interview with 9	SW #1 on 2/7/13 at					
		cated she had looked					
	·	sident's medical record					
		e to locate where the					
	resident had a	dental visit nor was					
	she able to loc	ate a consent for					
	dental services	5.					
	Interview with I	MDS Coordinator on					
	2/1/13 at 11:20	a.m., indicated he					
	normally check	s the resident's chart					
		admitted in order to					
	complete the M	IDS.					
	2. Resident #1	11's record was					
		30/13 at 1:00 p.m.					
		had a diagnoses of,					
	but not limited	to, dementia,anxiety,					
	hypertension, a	and hyperlipidemia.					
	Resident #111	's admission MDS,					
	dated 4/27/12,	indicated the resident					
		ssues. The quarterly					
		2/21/12, also indicated					
		d not have any dental					
	issues.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet Page 58 of 80

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/12/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE : COMPL	
7111D 1 E/1111	or conduction	155148		LDING		02/07/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	32,317	
NAME OF P	PROVIDER OR SUPPLIER				RWAY DR		
NORTH F	PARK NURSING CI	ENTER			VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710	REGUENTORT OR	ESC IDENTIFIEND IN ORDER TOOL		1710	<u> </u>		DATE
	Resident #111'	s family and POA					
		ney] was interviewed					
	·	2:41 p.m. Resident					
		OA indicated the					
	resident had lo	ose teeth and had lost					
		eth since coming to the					
		It the resident's gums					
		Resident #111's					
	,	icated the resident had					
		tist in the past but had					
		al visit since her					
	admission to th	e facility in April, 2012.					
	Interview with t	he SW [Social Worker]					
		:44 a.m., indicated the					
	resident had no	ot had a dental visit					
	since being ad	mitted to the facility.					
	SW #1 indicate	ed she did not know the					
		ny dental issues. SW					
		ould not locate the					
		ntal services that is					
	_	ne resident is admitted					
	1	SW #1 indicated she					
		follow up with the					
		ts to ensure the					
		their consents signed d she would speak with					
		amily to allow the					
	resident to hav	•					
		SW indicated the					
	• •	be visited by a dentist					
		the resident could visit					
	their own denti						
							<u> </u>

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 59 of 80

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/12/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/07/2013
NAME OF PROVIDER OR SUPPLIER NORTH PARK NURSING CENTER			IRWAY DR	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
Interview with a.m., indicated through" the reand was unable resident had a consent signed. Interview with 12/1/13 at 11:20 hired by the factor of the fact	SW on 2/7/13 at 9:56 she had "looked sident's medical record e to locate where the dental visit or a d for dental services. MDS Coordinator on a.m., indicated was cility as an assistant tor in April, 2012, and pemployment, the			
To A last are	OVIDER OR SUPPLIER ARK NURSING CI SUMMARY S (EACH DEFICIEN REGULATORY OR Interview with S a.m., indicated chrough" the re and was unable resident had a consent signed Interview with I 2/1/13 at 11:20 hired by the fact MDS Coordinal after beginning orevious MDS 3.1-24(a)(1)	DVIDER OR SUPPLIER ARK NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Interview with SW on 2/7/13 at 9:56 a.m., indicated she had "looked chrough" the resident's medical record and was unable to locate where the resident had a dental visit or a consent signed for dental services. Interview with MDS Coordinator on 2/1/13 at 11:20 a.m., indicated was nired by the facility as an assistant MDS Coordinator in April, 2012, and after beginning employment, the previous MDS Coordinator left. 3.1-24(a)(1)	IDENTIFICATION NUMBER: 155148 SYNING STREET. 650 FA EVANS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Interview with SW on 2/7/13 at 9:56 a.m., indicated she had "looked chrough" the resident's medical record and was unable to locate where the resident had a dental visit or a consent signed for dental services. Interview with MDS Coordinator on 2/1/13 at 11:20 a.m., indicated was nired by the facility as an assistant MDS Coordinator in April, 2012, and after beginning employment, the previous MDS Coordinator left. 3.1-24(a)(1)	DVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Interview with SW on 2/7/13 at 9:56 a.m., indicated she had "looked chrough" the resident's medical record and was unable to locate where the resident had a dental visit or a consent signed for dental services. Interview with MDS Coordinator on 2/1/13 at 11:20 a.m., indicated was nired by the facility as an assistant MDS Coordinator in April, 2012, and after beginning employment, the previous MDS Coordinator left. 3.1-24(a)(1)

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 60 of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155148	B. WIN			02/07/	2013
	PROVIDER OR SUPPLIER			650 FAI	ADDRESS, CITY, STATE, ZIP CODE IRWAY DR VILLE, IN 47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0428 SS=D	IRREGULAR, ACT The drug regimer reviewed at least licensed pharmacist in irregularities to the director of numust be acted up Based on obserecord review, ensure pharmacist were addressed reviewed for urmedications, in met the criteria (Resident #44, Resident #32) Findings included to the record individed, but we have the criterian was reviewed to a.m. The record individual to the following a medication of the following a medication of the same at least the criterian of the following a medication of the follow	nof each resident must be once a month by a sist. must report any e attending physician, and rsing, and these reports on. ervation, interview, and the facility failed to acy recommendations d for 3 of 10 residents nnecessary the sample of 10 who. Resident #50, de: record of Resident #44 on 02/05/13 at 8:10 ficated the diagnoses are not limited to, high blood pressure itis. 2013 Physician Order d, but was not limited g orders "Bumetanide or high blood pressure] in tab Give 2nd dose	F04	28	F428 Drug regimen review, regirregular, act on 1. Pharmacy recommendations have been addressed by the physician for resident #44, #50 and #32. 2. residents have the potential to affected by the alleged deficiel practice. Facility audit of pharmacy recommendations pending response was comple and addressed with physicians indicated. Nurses were in serviced on 2/26/13 per SDC related to addressing pharmacy recommendations and considering gradual dose reduction to avoid unnecessar medications. Pharmacy recommendations are received the DNS monthly. DNS forward recommendation to attending physician. The physician signs the order for the recommendati if agrees. The pharmacy is notified of the physician order. The DNS compares the original recommendation to the orders received, to ensure are recommendations have been addressed. Pharmacist review recommendations to ensure all	r All be nt eted s as	03/09/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 61 of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		155148	B. WIN			02/07/2013
			В. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	R			RWAY DR	
NORTH F	PARK NURSING C	ENTER			VILLE, IN 47710	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	wantOxycod	one IR [a narcotic			recommendations have been	
	medication for	pain] 5 [five] mg tablet			addressed. 3. Nurses were in	1
	take 1[one]-2 [two] tablets (5 [five]-10				serviced on 2/26/13 per SDC	
		/ 4 [four] hours as			related to addressing pharmac	У
	needed for pai				recommendations and considering gradual dose	
	i necaca ioi pai				reduction to avoid unnecessar	v
	The Nets T. A	tto a dia a			medications. Pharmacy	'
	The Note To A	•			recommendations will be	
		scriber dated 12/11/12			addressed with the physician	
	· ·	vas not limited to, the			monthly and placed on the	
	following Phari	macy			residents' charts. The DNS wil	I
	Recommendat	ions, "Bumetianide			ensure that the pharmacy	
	needs frequen	cyOxycodone: CMS			consultant recommendations a	
		edicare and Medicaid			completed. Pharmacy consulta	ant
	-	noti [sic] support			will review previous month recommendations to ensure th	.oro
	_				is appropriate follow up. 4. DN	
		[sic] chose [sic] either			designee complete unnecessa	l l
		o] tiabletis [sic]". The			medication monitoring tool 5x	ii y
		y documentation the			week for 2 weeks, 3x week for	2
	physician had	been notified of the			weeks, 2x week for 2 weeks, t	l l
	Pharmacy reco	ommendation.			weekly x 6 weeks and monthly	for
					3 months to ensure that	
	During an inter	view on 02/05/13 at			pharmacy recommendations,	
	1	DoN [Director of			including gradual dose reducti	
		ated the pharmacy			are considered and addressed	
		ons had not been			Failure to comply with guidelin will result in disciplinary action	l l
					to and including termination.	up
		d still needed to be			Results of unnecessary	
	followed up on	"			medication monitoring tool will	be
					monitored in QA for a minimur	
	During an inter	view on 02/07/13 at			6 months, if a threshold of 95%	l l
	2:49 p.m. The	DoN indicated the			not met an action plan will be	
	facility did not	have a policy related to			developed. 5. Completion Dat	te:
		·			March 9 th , 2013	
	pharmacy recommendations. She further indicated, at that time,					
	l ·	ommendations should				
	be addressed	within 30 (thirty) days.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 62 of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155148	B. WIN	IG		02/07/	2013
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SUFFLIER	X.		650 FAI	RWAY DR		
NORTH	PARK NURSING C	ENTER		EVANS	VILLE, IN 47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		32 was observed to be					
	sleeping in a chair in the activity area on 1/30/13 at 11:00 a.m.						
		s clinical record was					
		/31/13 at 10:10 a.m.					
		as admitted to the					
		/11 with diagnoses					
	including, but r	·					
		ychosis, anxiety state,					
		euralgia, hypertension,					
	, , ,	ongestive heart failure,					
		ar disease, and					
	arthropathy.						
	The physician!	a andana aismaad					
		s orders, signed					
	to, the followin	led, but were not limited					
		y. ntianxiety] 0.25 mg 1					
		at bedtime "*hold for					
	sedation*" sinc						
		epressant] 20 mg po					
	daily	epressantj zo my po					
	1	ntipsychotic] 0.25 mg					
		y since 8/25/11					
		9 011100 01201 1 1					
	Resident #32 h	nad a care plan, dated					
		ng at risk for adverse					
	side effects rel	•					
	psychotropic m						
		ncluded, but were not					
	limited to, the f	·					
		ds as ordered, observe					
	for effectivenes	·					
		ment for tremors and					
	, mino [0000031	none for a cition a and					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet Page 63 of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPL	CONSTRUCTIO	N	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		COMPLET	
		155148	B. WING			02/07/20	013
NAME OF B	ADOLUDED OD GLIDDLIEF		STRE	ET ADDRESS, CI	TY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	C	650	FAIRWAY DF	२		
NORTH F	PARK NURSING C	ENTER	EVA	NSVILLE, IN	47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PRO	VIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CO	DRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIA	TE (COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
	associated side	e effects of					
	psychotropic m	nedication] assessment					
	two times per y	/ear					
	Document side	e effects as observed					
	and notify MD						
		de effects antipsychotic					
		-antipsychotic meds					
		review meds routinely					
		10 view meas routinery					
	On 2/1/12 at 0:	:30 a.m., pharmacy					
		ons were requested					
		•					
		or of Nurses [DoN] for					
		or Resident #32. She					
		ort at 11:00 a.m. on					
	2/1/13, indicati	•					
		ons" in October and					
	November, 20						
		on dated 12/11/12					
		ne artificial tears and					
	routine fluticas	one [nasal steroid					
	spray]. She pr	ovided no further					
	information to i	indicate the pharmacist					
	had made any	recommendations					
	regarding the r	esident's psychoactive					
		the past 12 months.					
		ated at that time she					
	could not find a						
	recommendation	•					
	3 Resident #F	50's clinical record was					
		30/13 at 11:05 a.m.					
		as admitted to the					
		/12 with diagnoses					
	including, but r	ioi iimitea to,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet Page 64 of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155148	B. WIN	IG		02/07/	2013
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
NODTIL		ENTED			RWAY DR		
NORTH	PARK NURSING C	ENTER		EVANS	VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)		DATE I
		, dementia and					
	transferred out	The resident was					
		t on 12/5/12 and					
	l · •	facility on 12/21/12.					
		racility of 12/21/12.					
	The record inc	luded, but was not					
		sician's orders, dated					
		:30 a.m., for the					
	following media						
		chotic medication] 5					
] at 1600 [4:00 p.m.]					
		every 6 hours as					
		reme anxiety/agitation.					
		sychotic medication] 40					
		laily to start 12/25/12.					
		,					
	Upon admission	on 12/21/12, the					
	resident also h	ad orders for					
	Lorazepam [ar	ntianxiety medication]					
	0.5 mg by mou	ith every 4 hours as					
	needed. Revie	ew of the Medication					
	Administration	Record indicated the					
	resident receiv	ed lorazepam on					
	12/23/12, 12/2	5/12, and 12/26/12.					
	Additional phys	sician's orders					
	included, but w	vere not limited to, the					
	following:						
	"1/2/13 ABH G	el [topical preparation					
		an [antianxiety],					
	, .	nistamine], and Haldol					
	[antipsychotic]	Full Strength Topical					
	Q [every] 4 Hrs	s PRN." For increased					
	anxiety.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet Page 65 of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIF	PLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	00	COMPL	
		155148	B. WING			02/07/	2013
NAME OF D	PROVIDER OR SUPPLIER		STI	REET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		65	0 FAI	RWAY DR		
	PARK NURSING C	ENTER	EV	/ANS\	VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TA	G	DEFICIENCY)		DATE
		zapine [Zyprexa,					
		5 milligram [mg] tablet					
	by mouth once	-					
	12/21/12 Olanz	zapine 10 mg one					
	tablet by mouth	n once daily at 5:00					
	p.m.						
	12/21/12 Diphe	enhydramine [Benadryl,					
	antihistimine] 2	25 mg by mouth twice					
	daily						
	,						
	A pharmacy re	commendation in the					
	•	dated 1/14/13,					
	indicated the fo	-					
		Pt. [patient] is on abh					
		orazepam [Ativan],					
	haldol and	orazepam [Auvan],					
		to a faith name and (aid)					
		nefuthrermore (sic),					
	•	n haldol and ativan					
		ce daily benadryl. the					
		o diagnosis. perhaps it					
		ed to 25 mg in the					
	•	If pt needs both the					
	_	e oral ativan and					
	haldol, perhaps	s the oral ativan could					
	be lowered from	m q4h prn [as needed]					
	to q6h prn and	the haloperidol					
	• •	img to 2 mg? Or					
		f the oral agents could					
	•	ntinued]; although both					
	_	he gel, there is still the					
	•	oling up on them. also					
		a 10 mg at 1700.					
		ould be moved to					
	•	imize dizziness,					
		· · · · · · · · · · · · · · · · · · ·					
	drowsiness, se	tuation? THE					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet Page 66 of 80

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/12/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE : COMPL		
		155148	A. BUI B. WIN	LDING		02/07/	
NAME OF B	DOLUBED OD GUDDU ED		D. WIIV		DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	ROVIDER OR SUPPLIER				RWAY DR		
NORTH F	PARK NURSING CI	ENTER		EVANS	VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		on indicated it was		0			J.112
		ysician on 1/14/13.					
	-	esponse to the					
	recommendation	on in the record.					
	There was no i						
	pnarmacy reco	mmendation was ever					
	acica apon.						
	The Director of	Nurses indicated on					
	2/6/13 at 2:00 ¡	o.m., there was no					
	further informa	tion regarding the					
	pharmacy reco	mmendation.					
	3.1-25(i)						
	0.1 20(1)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 67 of 80

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155148	B. WING		02/07/2013
	PROVIDER OR SUPPLIER		650 FA	ADDRESS, CITY, STATE, ZIP CODE NRWAY DR SVILLE, IN 47710	
(V4) ID	CLIMMADY C	TATEMENT OF DEFICIENCIES	ID		(V5)
(X4) ID PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	l `	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE DATE
F0441	483.65	LSC IDENTIFY TING INFORMATION)	IAG		DATE
SS=D	INFECTION CON SPREAD, LINEN The facility must	ITROL, PREVENT S establish and maintain an Program designed to			
	provide a safe, sa environment and	anitary and comfortable to help prevent the transmission of disease			
	Control Program (1) Investigates, of infections in the form (2) Decides what	establish an Infection under which it - controls, and prevents			
	resident; and (3) Maintains a re	ecord of incidents and s related to infections.			
	determines that a prevent the sprea must isolate the r (2) The facility mu a communicable lesions from direct their food, if direct	ection Control Program resident needs isolation to ad of infection, the facility			
	their hands after	ust require staff to wash each direct resident contact ashing is indicated by ional practice.			
	transport linens s of infection. A. Based on o	bservation, interview	F0441	<u>F441</u> Infection control, prever spread, linens	ot 03/09/2013
	and record rev	iew, the facility failed to	Ī	spicau, iiilelis	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 68 of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLE	TED
		155148	B. WIN			02/07/2	013
		1	b. Wilv		ADDRESS, CITY, STATE, ZIP CODE	L	
NAME OF F	PROVIDER OR SUPPLIEF	₹			IRWAY DR		
NORTH I	PARK NURSING C	ENTER			VILLE, IN 47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	ensure the infe	ection control program					
	was implemen	ted to prevent possible			1.1. Individualized action	1	
	transmission o	f infections from one			plan initiated with RN#1 on 1/31/2013. RN#1 was unable to	to	
	resident to and	other, for 2 of 4			successfully complete the	.0	
		f blood glucometer			requirements of the individual		
		3 units (Station I), in			action plan and has been		
		neter was not sanitized			terminated. Infection control		
		ents. (Resident #9,			procedures are followed	.	
	Resident #137				regarding glucometer usage a	nd	
	1 TCSIGCITE#107	,			cleaning. Resident #9 skin assessed on 1/31/13, no adve	rea	
	D Dood on o	been estion interview			effects noted. Resident #9 is	136	
		bbservation, interview			receiving wound treatment per	-	
		iew, the facility failed to			physician order.		
		n control procedures					
		to prevent potential					
		f infection from one			2. All residents are		
	wound to anoth	her, for 1 of 1 resident			identified to have the potential	to	
	with pressure s	sores, in the sample of			be affected by the alleged deficient practice. Nurses were	a in	
	3 residents rev	riewed for pressure			serviced on 2/26/13 per SDC	- "'	
	sores. (Reside	ent #9)			related to infection control		
	,	,			practices during wound care a	nd	
	Findings includ	de:			proper sanitizing of glucomete		
					to prevent possible transmission		
	A.1. On 1/31/1	13 at 11:10 a.m., RN #1			of infection. Skill validations fo		
		to do a blood glucose			glucometer cleaning and dress changes were completed for a	-	
		dent #137. RN #1			nurses.	"	
		eter back in a lancet					
	1 '	to the medication cart.			3. Nurses were in serviced on	ı	
					2/26/13 per SDC related to		
		to Resident #137's			infection control practices duri		
	· ·	esident #9, "let me just			wound care and proper sanitize	ang	
	1	s and I'll be back for			of glucometers to prevent possible transmission of infect	ion	
	•	the room and used			Nurses will be required to		
	sanitizer on her hands in the hallway.			successfully complete skills			
		to the cart and set the			competencies for		
	box with the gl	ucometer in it on top of			treatment/dressing changes a	nd	
	the medication	cart. She checked			glucometer cleaning during		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) I			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUILDIN	NG.	00	COMPL	ETED
		155148	A. BUILDIN B. WING	NU		02/07/	2013
				TDEET V	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			RWAY DR		
NODTH	PARK NURSING C	ENTED			VILLE, IN 47710		
NORTH	- ARK NURSING C	LNIER		VANS	VILLE, IN 47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	II		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
	the Medication	Administration record			orientation and at least quarte	rly	
	[MAR] and the	n picked up the box			thereafter. Rounds will be		
	with glucomete	er in it and carried it into			conducted by DNS/Designee to ensure appropriate glucomete		
	Resident #9's	bedside and set it on			cleaning occurs and infection	!	
	the resident's a	abdomen			control is provided during		
					treatment changes.		
	At that time th	a nursa was requested					
		e nurse was requested			4. DNS/ designee will complet	e	
		glucometer and box			skills competencies during		
	and leave the				treatments and/or dressing		
	medication car	t, she was interviewed			changes with nurses 5x week		
	regarding any	procedures for			2 weeks, 3x week for 2 weeks		
	cleaning/saniti	zing the glucometer.			week for 2 weeks, then weekly	/ X	
	She indicated	she cleaned the meters			6 weeks and monthly for 3 months ensure residents recei	ivo	
	if they were so	iled or had blood on			treatment and services to prev		
		ise, she just did it at the			infection and promote healing.		
		•			DNS/ designee will complete	•	
		t. She showed me a			skills competencies related to		
	•	e drawer that she used.			glucometer checks 5x week for	or 2	
		she did not do it every			weeks, 3x week for 2 weeks, 2	2x	
	time. "I'm guilt	y," she stated.			week for 2 weeks, then weekly	/ X	
					6 weeks and monthly for 3		
	At 11:50 a.m. o	on 1/31/13, the Director			months to ensure that infection		
	of Nurses [Dol	N] and Administrator			control procedures are followed		
	_	ed. They indicated			prevent potential transmission infection. Failure to comply with		
		erved was not their			guidelines will result in	u I	
		#1 had reported to			disciplinary action up to and		
		•			including termination. Results	of	
	•	ppened. The DoN			skills competencies will be		
		t1 had already been			monitored in QA for a minimur		
		12:00 noon, they			6 months, if a threshold of 95%	∕₀ is	
	indicated the n	urse was not allowed			not met an action plan will be		
	to do any bloo	d glucometer checks			developed.		
	until she was n	nonitored and everyone			E Commission Detection 1 04	L	
	was being re-ir	-			5. Completion Date: March 9 t	n,	
					2013		
	The policy and	procedure for Glucose					
		•					
	ivieter Cleaning	g and Testing, dated					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 70 of 80

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 02/07/	LETED	
		100110	B. WIN			02/01/	72010
NAME OF F	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE		
NORTH I	PARK NURSING C	ENTER			RWAY DR VILLE, IN 47710		
				<u> </u>	VILLE, III 477 10		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
TAG		· · · · · · · · · · · · · · · · · · ·		IAU			DATE
	•	ided by the Director of 1/13 at 12:05 p.m. The					
		·					
	policy and procedure included, but						
		•					
		, testing equipment and					
		dent					
	•						
		•					
		_					
		esident's iniger lip with					
	•	or tip to air dry					
	_	•					
	_	-					
		lent's iniger up with					
		ale droplet of blood					
		•					
	_	-					
	·						
		•					
		paper tower and					
	_						
		fused lancet and					
	•						
	1	•					
	-						
		bamer and gloves in					
		er on naner towel on					
	was not limited "11. Wash or s 12. Proceed to cleaned meter, supplies. 13. Verify residual 14. Place cleat cup or clean bat 15. Placed cle towel, in plastid 16. Put on cleat 17. Cleanse re alcohol wipe. 18. Allow finger 19. Insert read 20. Prick residuancet. 21. Obtain sin 23. Wait for re 24. Check fing 25. Remove g 26. Gather metalcohol wipes, gloves. 27. Exit room 28. Dispose of reagent in shar 29. Dispose of towel or clean trash.	I to, the following: sanitize hands. The resident room with the testing equipment and surface. The resident room with the paper towel, plastic farrier on hard surface. The resident room paper to cup or clean barrier. The resident's finger tip with the resident's finger tip with the resident's finger tip with the resident of blood The resident room with the resident room paper towel and the resident room paper towel on the room paper towel on the resident room paper towel on the room p					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 71 of 80

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155148		LDING	NSTRUCTION 00	(X3) DATE COMPL 02/07/	ETED
	PROVIDER OR SUPPLIER		<i>p.</i> wiiv	STREET A	ADDRESS, CITY, STATE, ZIP CODE RWAY DR VILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	*Note: If blood the meter, two One wipe to cle blood or soiling disinfect. Cleaning meter using on next rows 31. Wash or some 32. Place clear cup or clean be 33. Put on glood 34. Obtain sing wipe, Super Some 35. Wipe entire the blood glucon 2 minutes and wet for 2 minutes and wet for 2 minutes 36. Place clear towel, in plastic 37. Allow meter 38. Dispose of paper towel in 39. Remove got trash. 40. Wash hand B.1. Resident reviewed on 1/2 resident was a from the hospit diagnoses included.	is visibly present on wipes MUST be used. ean i.e. remove visible and second wipe to rafter use/prior to esident: anitize hands. In paper towel, plastic arrier on hard surface. It is is gle-use germicidal eni-Cloth. It is external surface of the external surface of the external surface of the ese meter with wipe for ensure meter stays the time period. In meter on clean paper is cup or clean barrier. For the dry completely. It is to dry completely. It is dispose in the dispose in th		TAG	DEFICIENCY)		DATE
	sclerosis. The	cancer and multiple resident was admitted ith a history of a					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 72 of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148			LDING	00	COMPL: 02/07/		
		100140	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	02/01/	2010
NAME OF F	PROVIDER OR SUPPLIER			1	RWAY DR		
NORTH PARK NURSING CENTER					VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE	COMPLETION DATE
	ischium [lower and had been the home health are prior to admiss developed add	re area on her left buttock/upper thigh] reated at home with nd a wound care clinic ion. The resident itional areas after					
	admission. The clinical rec	ord included					
	follows: "1) (L) [left] iso NS [normal sal surrounding [w prep surroundi [debriding ager tissue] to necro [with] aquacel a [with] ABD et s	ers, dated 1/30/13, as chial wound, flush [with] ine] cleanse ith] NS, pat dry, skin ng tissue, apply Santyl nt to eliminate necrotic otic tissue, pack wound AG cut to size, cover ecure [with] Meplex BID [twice a day]					
	gluteal wound, cleansed [with] surrounding tis	attock wound, (R) (L) gluteal wound to be NS, pat dry, skin prep sue, hydrogel [gel to g] applied to wound d meplex foam					
	CNA #1 were of treatment to Red dressing was in The resident w	10:38 a.m., RN #1 and observed to provide esident #9. No n place at that time. as observed to have on the left ischium, at					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 73 of 80

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/12/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 155148	A. BUILDING 00		COMPLETED 02/07/2013		
		100140	B. WIN		DDDEGG GUTY GTATE TID GODE	02/01/	2010
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE RWAY DR		
NORTH PARK NURSING CENTER					VILLE, IN 47710		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	-	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		e, with significant					
		sured at that time,					
		e yellow slough in the					
	wound bed. Sta	-					
		e loss with exposed					
		or muscle. Slough or					
	-	present on some parts					
		d. Often includes					
	_	nd tunneling]. One					
		one had irregular					
	•	mately 2.5 cm by 2 cm,					
	•	ulation, some yellow					
	-	rea on the lower right					
	buttock/ischium	n 1 cm by 1 cm, had					
	red tissue plus	some yellow slough.					
	One more area	on the right side of					
	the coccyx was	observed as 1 cm by					
	1 cm, red tissue	e with small amount of					
	yellow slough.	The last 3 areas were					
	stage II [partial	thickness loss of					
	dermis presenti	ing as a shallow open					
	ulcer with a red	I pink ulcer bed without					
	slough]	-					
	CNA #1 held th	e resident over on her					
	right side as far	r as she could. The					
	_	nall bottle of normal					
	saline and pour	red it over the					
	resident's butto						
	The nurse then	obtained Santyl					
		nt to loosen necrotic					
		elled the ointment onto					
	a gauze pad. S						
		he 3 smaller areas on					
			1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 74 of 80

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/12/2013 FORM APPROVED OMB NO. 0938-0391

		DENTIFICATION NUMBER:		ULTIPLE CO	00	(X3) DATE S COMPL	
155148			LDING		02/07/		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				IRWAY DR		
NORTH I	NORTH PARK NURSING CENTER				VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		*		TAG	Dia lettike 17		DATE
	-	and right lower There was a large					
		tyl placed on these					
		on the necrotic slough					
	•	plied the ointment on					
		using the same gauze					
		l; she did not use a					
	•	ad and fresh Santyl on					
		e did not put any of the					
		ecrotic tissue on the					
	left ischial area	. She then wore the					
	same gloves a	nd packed the large					
	ischial area wit	h medicated "roping,"					
	identified as Ad	quacel AG. She used					
	skin prep on th	e healthy skin around					
	all the areas ar	nd then applied two					
	large foam dre	ssings to cover the					
	areas.						
	Upon interview	with the Director of					
	Nurses on 1/31	I/13 at 11:50 a.m., she					
	indicated the n	urse should have					
		rea separately and					
	followed the or	ders for treatments.					
	•	for Dressing Change,					
	dated 1/2010 a	ind reviewed 9/2012,					
	•	y the Director of					
		13 at 9:15 a.m. The					
	·	uded, but was not					
	limited to, the f	_					
		and physician orders					
	Provide privacy	and explain					
	procedure						
	Set up clean fi	eld to ensure easy					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 75 of 80

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155148	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 02/07/	ETED
	PROVIDER OR SUPPLIER			650 FAII	DDRESS, CITY, STATE, ZIP CODE RWAY DR VILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Remove gloves Perform hand I Put on gloves Initiate wound physician orde "Wound care re a) Cleanse aw from the wound b) Cleanse fro outward c) Cleanse in (d) Use a sepa each cleansing e) If drain pres circular motion moving outwar f) Measure wo Remove gloves Perform hand I Put on gloves	s and discard rygiene care according to the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 76 of 80

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/12/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155148	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPI 02/07	LETED		
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR					
NORTH I	NORTH PARK NURSING CENTER			VILLE, IN 47710				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 77 of 80

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA (X		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. BUILDIN		BUILDING 00		COMPLETED		
		155148	B. WIN			02/07/	2013	
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER				IRWAY DR			
NORTH F	PARK NURSING CE	ENTER			VILLE, IN 47710			
(X4) ID	SUMMARY S	SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0518 SS=D	emergency proce work in the facility procedures with a unannounced sta procedures. Based on obse record review, ensure facility	DRILLS Train all employees in dures when they begin to r, periodically review the existing staff; and carry out ff drills using those Trvation, interview, and the facility failed to estaff knew the proper	F05	18	F518 Train all staff emergency procedures/drills		03/09/2013	
	that, 1 of 5 laur not know the ga turned off in the	e event of a fire, in andry staff members did as supply needed to be event of a fire and the location of the gas			A sign was posted in the laundry room to indicate the location of the gas shut off valuand an in-service was initiated with the laundry staff on 2/5/20 per the Housekeeping supervite. All residents have the potential to be effected by the alleged deficient practice. Staff	ve 013 sor.		
	02/05/13 at 2:0 #1 indicated in the laundry, sh extinguisher ar for help right av dryer off with the the front of the				serviced related to location of shut off valve to the dryer on 2/26/13 per SDC. 3. Location of the gas shut valve to the dryer will be review with new employees and has been added to the job specific orientation checklist.	off wed		
	shut off they not buring an intermediate Daring an intermediate Daring to be standing	ectric if there is a gas ever told me about it." view, at that time, the birector was observed in an open space ers and indicated the			4. Housekeeping supervisor/ designee will complete an emergency preparedness monitoring tool 5x week for 2 weeks, 3x week for 2 weeks, 2 week for 2 weeks, then weekly 6 weeks and monthly for 3 months to ensure that facility s know proper procedure in the	/ X		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet Page 78 of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		155148	B. WIN			02/07/2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	8				
NORTH PARK NURSING CENTER				IRWAY DR		
NORTH	PARK NURSING CI	ENTER		EVANS	VILLE, IN 47710	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	drvers were ga	s fueled and was able			event of a fire. Results of the	
	, ,	act location of the gas			emergency preparedness	
	shut off valve.	actionalist of the gas			monitoring tool will be monitore	
	Shat on valve.				in QA for a minimum of 6 mon	
					if a threshold of 95% is not me	
	_	off valve was observed			an action plan will be develope	ed.
		2:15 p.m., to be			5 Completion Detection 1	
	located behind	an unmarked closed			5. Completion Date: March 9 to 2013	Π,
	door, on an ex	posed pipe in the			2013	
		narked, twisted hanger				
	•	to be hanging down				
	from the turning					
		g mechanism.				
		51 51 1 411				
		file of Laundry Aide #1				
	was reviewed	on 02/05/13 at 2:30				
	p.m. The emple	oyee file indicated				
	Laundry Aide #	1 had been inserviced				
	1	upon hire. The				
	employee file la	•				
		-				
		that Laundry Aide #1				
	had been inser					
	emergency gas	s shut off in the				
	laundry.					
	During an inter	view on 02/05/13 at				
	2:40 p.m. the F					
	•	. •				
		ted, "I thought she				
		she doesn't, I will				
	1	body right away and				
	mark the gas s	hut-off pull"				
	During an inter	view on 02/05/13 at				
	•					
	3:50 p.m. the H	. •				
		icated the proper				
	procedure to fo	ollow in the event of a				
	fire was to turn	the gas off				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet Page 79 of 80

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/12/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155148	B. WING		02/07/2013
	PROVIDER OR SUPPLIE		650 FA	ADDRESS, CITY, STATE, ZIP CODE IRWAY DR SVILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
1716	immediately.	RESCRIPTION TRACER ORGANIZATION	Ind		BATE
	During an inte 9:01 a.m., the Supervisor incovere taught all dryer but, it did instructions for off. He further he used the G and the Disast employee ories. The General F Disaster Manu [Health Facilities of the General F Disaster Manu [Health Fac	r emergency gas shut rindicated, at that time, eneral Fire Action Plan ter Manual during new intation. Fire Action Plan and the lal provided by the HFA es Administrator] on 30 p.m. lacked any related to shutting off rin the laundry in the			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3TWK11

Facility ID: 000069

If continuation sheet

Page 80 of 80